Kansas | Healthy Blue | Medicaid

Provider Manual

833-838-2595

https://healthybluekansas.com/provider

KanCare | Healthy Blue

KSHB-CD-PM-061368-24

November 2024

General information about this manual

Healthy Blue retains the right to add to, delete from and otherwise modify this manual. We will notify network providers as soon as possible of any changes to this manual.

Material in this provider manual is subject to change. Please go to https://healthybluekansas.com/provider.

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Table of Contents

Welcome to Healthy Blue. We're glad to have you among our network of quality providers.

We recognize hospitals, physicians, and other providers play a pivotal role in managed care. Earning your respect and gaining your loyalty are essential to successful collaboration in the delivery of quality healthcare.

This provider manual contains everything you need to know about us, our programs, and how we work with you. This information is subject to change. **Please visit https://healthybluekansas.com/provider for the most up-to-date information.**

We want to hear from you! Participate in one of our quality improvement committees or call our Provider Relations team with suggestions, comments, or questions. Together, we can make a difference in the lives of our KanCare members.

1. INTRODUCTION

Who We Are

Healthy Blue was formed specifically to serve Medicaid enrollees. We are able to leverage 30 years of Medicaid experience. Our Medicaid expertise — combined with the strong and longstanding provider relationships held by Blue Cross and Blue Shield of Kansas and Blue Shield of Kansas City across all 105 counties in Kansas — will position Healthy Blue to infuse both innovation and accountability to the KanCare program.

We:

- Improve access to preventive healthcare services.
- Ensure our members select primary care providers who serve as providers, care managers, and coordinators for all basic medical services.
- Help improve health outcomes for members.
- Educate our members about their benefits, responsibilities, and appropriate use of care.
- Utilize community-based enterprises and community outreach to help our members.
- Integrate physical and behavioral health care to address the whole person.
- Encourage:
  - Stable relationships between our providers and members.
  - Appropriate use of specialists, urgent care centers, and emergency rooms.

In a world of escalating healthcare costs, we work to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their healthcare.

Provider Enrollment – Join Healthy Blue

To become part of the Healthy Blue network, providers must use the **Kansas Medical Assistance Program (KMAP) Provider Portal** and **Enrollment Wizard**. All providers serving KanCare members must be screened and enrolled through this system.

All providers may need the following minimum information to complete your enrollment request:

- Address information
- Tax Identification Number/Social Security Number
- W-9
- Application Fee

Additional information may also be required depending on provider type such as:

- National Provider Identifier
- Taxonomy code(s)
- License Number(s) and Effective Dates
- CLIA Number and Effective Dates – if billing laboratory codes

During the application process, KMAP will direct the applicant to choose the Managed Care Organization(s) (MCO) which they want to pursue a contract. To become part of the Healthy Blue Network, select Healthy Blue from the drop down MCO options once available during that step of the application and enrollment processes. All documentation that is captured within KMAP, will be electronically communicated to Healthy Blue.

KMAP approval does not guarantee participation in the Healthy Blue network. You must be contracted and credentialed by Healthy Blue prior to providing services to a KanCare member.

Provider and Facility Digital Guidelines

Healthy Blue understands that working together digitally streamlines processes and optimizes efficiency. We collaborate with the State of Kansas by way of the KMAP Provider Portal and have developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

Healthy Blue expects providers and facilities to utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business for KanCare and with Healthy Blue. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass **KMAP Portal**, **Availity.com**, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Healthy Blue and the State have available to participating and nonparticipating providers and facilities who serve KanCare members. The expectation of Healthy Blue is based on our contractual agreement that providers and facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Provider Enrollment:

- Kansas Medical Assistance Program (KMAP) Provider Portal
- The Provider Enrollment Wizard

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, disputes, and claim status

- Remittances and payments
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Healthy Blue expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (for example, paper, mail, fax, call, chat). All channels are consistent with industry standards. All EDI transactions use version 5010.
Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software and clearinghouse billing vendors.

Providers and facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards
As our members transition to digital member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Healthy Blue expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application. Providers and facilities may also access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response
Providers and facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- Provider must use the State of Kansas Electronic Visit Verification system to receive, review and either accept or deny authorizations for the EVV Covered HCBS-PCS and Home Health Care Services (HHCS). The list of services covered by the State of Kansas EVV program can be found at: EVV Page at the KanCare website: **https://www.kancare.ks.gov/providers/training-resources/electronic-visit-verification**
- EDI transaction: X12 270/271 – eligibility inquiry and response:
  - Healthy Blue supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- Availity Essentials:
  - The Eligibility and Benefits Inquiry verification application allows a provider and facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
  - Healthy Blue has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals

Providers and facilities should leverage these channels for prior authorization submission, status inquiries, and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Healthy Blue supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Healthy Blue supports the industry-standard X12 275 transaction for electronic transmission of supporting authorization documentation, including medical records, via the HL7 payload.
- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application:
    - This application enables prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations. Clinical Appeals and Behavioral Health Services will route to the application used for these services.
- Provider desktop integration via B2B APIs:
  - Healthy Blue has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

<u>Claim submissions status and claims payment disputes</u>

Providers and facilities should leverage these channels for electronic claim submission, attachments (for both pre- and post-payment), and status:

- EDI transaction: X12 837 – Professional, institutional, and dental claim submission (version 5010):
  - Healthy Blue supports the industry-standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
  - 837 Claim batch upload through EDI allows a provider to upload a batch/file of claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Healthy Blue supports the industry-standard X12 276/277 transaction set for claim status inquiry and response as mandated by *HIPAA*.
- Availity Essentials: The Claims & Payments application enables a provider to enter a claim directly into an online claim form and upload supporting documentation for a defined claim.
  - Claim Status application enables a provider to access online claim status. Access the claim payment dispute tool from Claim Status by locating the claim, initiating the dispute, and routing to the Availity Appeals application for submission of dispute. It is the expectation of Healthy Blue that electronic claim payment disputes are adopted when and where it is integrated.

- Provider desktop integration via B2B APIs:
  - Healthy Blue has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Providers must use the State of Kansas EVV Application for the review and submittal of original claims for **EVV Covered HCBS-PCS and Home Health Care Services (HHCS)**. Beginning January 22, 2025, this is the only approved method for original claims submittals for EVV Covered HCBS-PCS and Home Health Care Services (HHCS). Electronic Visit Verification PCS and HHCS visit codes can be found at **https://www.kancare.ks.gov/home/showpublisheddocument/1146/638576002343130000**.

Claim attachments

Providers and facilities should leverage these channels for electronic claim attachments from **Availity.com**:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Healthy Blue supports the industry standard X12 275 transaction for electronic transmission of supporting claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a provider or facility to digitally submit supporting claims documentation, including medical records, directly to the claim:
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records is needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Healthy Blue supports the industry standard X12 835 transaction as mandated per *HIPAA*.

Providers and facilities can register, enroll, and manage ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop 31 days after the ERA enrollment date:

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of Remittance Viewer include the ability to search a two-year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY (282-4548)**.
To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically:

- **Electronic Funds Transfer (EFT)** uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation:
  - **To enroll in EFT:** Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual**.
  - **To disenroll from EFT:** Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.
- **Virtual Credit Card (VCC):** For providers and facilities who don't enroll in EFT, and in lieu of paper checks, Healthy Blue is shifting some reimbursements to Virtual Credit Card (VCC). VCC allows providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply. Note that Healthy Blue may receive revenue for issuing a VCC:
  - **Opting out of VCC payment:** Providers and facilities are entitled to opt out of electronic payment. To opt out of VCC payment, there are two options:
    - Enrolling for EFT payments automatically opts you out of VCC payments. To receive EFT payments instead of VCC payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    - Contact Comdata at **800-833-7130** and provide your taxpayer identification number.
- **Zelis Payment Network (ZPN) electronic payment and remittance combination:** The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services. Note that Healthy Blue may receive revenue for issuing ZPN. ERA through Availity is not available for providers and facilities using ZPN:
  - **To disenroll from ZPN payment**, there are two options:
    - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    - Update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

2. QUICK REFERENCE CONTACT INFORMATION

Our Website

Our provider website, **https://healthybluekansas.com/provider**, offers a full complement of tools including:

- Enhanced account management tools for timely updates to your contact information in our systems.
- Downloadable forms.
- A detailed eligibility look-up tool.
- Comprehensive, downloadable member panel lists and population-centric reporting.
- Easier authorization requirements look-up and submissions.
- Access to drug coverage information.
- Special training for you and your office staff.
- A list of open claim-related issues and their status.

For technical support when using our provider website, call our Technical Support team at **866-755-2688**. Agents are available between 8 a.m. to 5 p.m. Central time.

Contact Information

If you have questions about. . .	Contact
Kansas Department of Health and the Environment (KDHE)	Phone: **785-296-3982** **kdhe.ks.gov** KanCare: **kancare.ks.gov** KanCare Clearinghouse contact info: **800-792-4884**
State of Kansas Electronic Visit Verification (EVV)	KDHE.EVV@ks.gov
Healthy Blue Website	**https://healthybluekansas.com/provider** Availity Essentials: Log in at **Availity.com** These sites feature tools for real-time eligibility inquiry, claims submission/status/appeals, and prior authorization requests/status/appeals. In addition, the sites offer general information and various tools that are helpful to the provider such as: • *Preferred Drug List* • List of drugs requiring prior authorization • Provider manuals • Referral directories • Provider newsletters • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Health plan and industry updates • *Clinical Practice Guidelines*

If you have questions about. . .	Contact
	• Downloadable forms
Member Eligibility Verification	Verifying member eligibility can be done via: • The KMAP website**: KanCare.ks.gov** • Healthy Blue Provider Services: **833-838-2595** • **Availity Essentials: Availity.com** • The KanCare Clearinghouse: **800-792-4844**
Healthy Blue Provider Services	Monday through Friday 8 a.m. to 5 p.m. Central time Phone: **833-838-2595** Fax: **800-964-3627** (Prior Authorization) Interactive Voice Response (IVR) system available 24 hours a day, 7 days a week. Use the referral directory on our provider self-service site to find other Healthy Blue network providers and substance use disorder services. For assistance in referring members to services and providers near them, call our Provider Services team.
Questions/Issues	Our Provider Experience program helps you with claims payment and issue resolution. Call Provider Services **833-838-2595** and select the *Claims* prompt within our voice portal. Provider Services is available to assist you in determining the appropriate process to follow for resolving your claim issue. Non-claims issues can be filed electronically or verbally. • Call Provider Services: **833-838-2595** • Visit our website: **https://healthybluekansas.com/provider** • Contact your Healthy Blue provider relationship account management representative (also found on our website).
Behavioral Health National Provider Service Line	Behavioral Health National Provider Service Line **800-397-1630** Monday through Friday, 8 a.m. to 8 p.m. ET
Behavioral Health Services	KS Member: **833-838-2593** KS Provider: **833-838-2595** Prior authorization: All requests should be submitted electronically via **Availity.com**. If you prefer to paper fax: • Behavioral Health – inpatient: **866-852-8976** • Behavioral Health – outpatient: **866-852-8978**

If you have questions about. . .	Contact
Prior Authorization	**https://healthybluekansas.com/provider** Requests for prior authorizations may be submitted as indicated below. Digital submission (preferred method): **Availity.com** **Phone/fax submission -** contact Healthy Blue: • Inpatient/Outpatient surgeries: – Fax: **800-964-3627** – Phone: **833-838-2595** • Emergent/Concurrent Inpatient services (fax): **866-852-2608** • Outpatient services (fax): **866-852-2844** • Therapy services (fax): **877-371-0393** Carelon Medical Benefits Management, Inc. at **careloninsights.com** (online) for: • Cardiology • Genetic testing • Musculoskeletal • Radiation oncology • Radiology (high-tech) • Sleep studies Documentation and forms required for prior authorization requests are available on the provider website.
National Provider Identifier (NPI)	The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* requires the adoption of a standard, unique provider identifier for healthcare providers. All Healthy Blue participating providers must have a NPI number. The NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers such as the states in which they practice or their specialties. For more information about the NPI and the application process, please visit **https://nppes.cms.hhs.gov**.
Pharmacy Prior Authorization	Pharmacy Benefit PA: • Electronic PA (e-PA) via CoverMyMeds (**covermymeds.com**) • Fax: **877-941-9901** • Phone: **833-838-2595** Physician Administered Drugs PA Medical Benefit:

If you have questions about. . .	Contact
	• Electronic PA (e-PA) via CoverMyMeds (**covermymeds.com**) • Fax: **877-941-9841** • Phone: **833-838-2595**
Integrated Care Coordination	Care coordinators are available from 8 a.m. to 5 p.m. Central time. For urgent issues, assistance is available after normal business hours, during weekends and on holidays at **833-838-4344**.
Claims Information	Availity Client Services: **800-AVAILITY (282-4548)** Availity EDI Payer ID: 00047: • To submit transactions directly to Availity or use a clearinghouse or billing company to submit your claims to the Availity EDI Gateway Contact Availity Client Services with any questions. Online claims submission: We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status, and prior authorization status. Visit **Availity.com**. If you are unable to access the internet, you may receive claims, eligibility, and prior authorization status over the phone by calling Provider Services at **833-838-2595**. Submit paper claims to: Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466 Timely filing is within 180 calendar days from the date of service or per the terms of the provider agreement.
Claim submissions	Healthy Blue uses Availity Essentials as its EDI Gateway Provider for batch and direct data entry claim submissions. Register for Availity Essentials by visiting **Availity.com** and selecting the **Get Started** link at the top of the page. Use Payer ID 00047 when submitting claims to Availity. For more information on setting up your account for claim submissions, review the Availity EDI Guide at **availity.com/documents/edi%20guide/edi_guide.pdf** Contact Availity at **800-AVAILITY** with questions on how to register to submit claims.

If you have questions about. . .	Contact
Claims: Correspondence	Submit claim correspondence using your EDI Vendor or though Availity Essentials, or submit a claim correspondence form to: **Claims Correspondence** **Healthy Blue** **P.O. Box 61599** **Virginia Beach, VA 23466-1599** Provided the claim was originally received timely, claim correspondence must be received within 365 days of the date of service.
Non-emergency medical transportation (NEMT) other than ambulance (provided through Access2Care)	Providers: **888-972-5808** Members: **833-270-2254**
Dental (provided through SKYGEN)	Providers: **855-434-9237** Members: **844-621-4575**
Vision (provided through EyeMed)	Providers: **844-844-0928** Members: **844-844-0928**
Lab and Diagnostic Services	LabCorp: **888-522-4452** Quest Diagnostics: **866-697-8378**
Interpreter Services	Telephonic services for those who are deaf or hard of hearing: 711 Non-English telephonic services: **833-838-2593** (Member Services, language line available) In-person interpretation: **833-838-2593** (Member Services)
Member Services	**833-838-2593** Live agents available Monday through Friday, 8 a.m. to 5 p.m. Central time Self-service voice portal available 24/7 Interpreter services are available
Member Grievances	Members can file a grievance at any time. Call **833-838-2593** or submit by mail to: Grievance Processing Healthy Blue P.O. Box 62429 Virginia Beach, VA 23466-2429
Member Appeals	Appeals must be filed within 60 calendar days from the date of the *Notice of Adverse Benefit Determination*, plus an additional three

If you have questions about. . .	Contact
	calendar days to allow for mailing/sending. You may appeal on behalf of a member with written authorization from that member. Members may submit appeals to: Healthy Blue P.O. Box 62429 Virginia Beach, VA 23466-2429 Members can also request appeals verbally by calling Member Services at **833-838-2593** (TTY 711), Monday through Friday from 8 a.m. to 5 p.m. Central time (after hours callers can leave a message and a member of our team will call them back). For members who don't speak English, we offer free interpreter services for all languages.
Nurse HelpLine for Members	**833-838-4344** (Spanish: **866-864-2545**) Live agents available 24/7
Claim Payment Reconsideration	Healthy Blue encourages providers to use our reconsideration process if you feel a claim was not processed correctly. We accept reconsiderations verbally by phone, online, and in writing within 120 calendar days (plus an additional three (3) calendar days to allow for mailing/sending) of the date on the *Explanation of Payment* (*EOP*). A reconsideration determination letter will be sent to providers advising of the outcome. For online submissions: • Use Availity Essentials Appeal tool at **Availity.com**. Locate the claim you want to dispute using Claim Status from the Claims & Payments menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation and submit. To navigate directly to the initiated dispute in the appeals dashboard, add the documentation and submit. • Phone: **833-838-2595** • Dispute address: Healthy Blue Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599

If you have questions about. . .	Contact
Claim Payment Appeals	If you do not agree with our determination on your reconsideration request or if you would prefer to bypass the reconsideration step, you may file an appeal online or in writing. If a provider chooses to request a reconsideration, a provider may terminate the reconsideration process and submit an appeal request within 60 calendar days of the date of the *Notice of Action*, plus an additional three (3) calendar days to allow for sending of the notice. If a provider does not submit an appeal request within 63 calendar days of the date of the *Notice of Action*, the provider must wait to receive the Notice of Reconsideration Resolution before filing an appeal. The provider must submit a request for an appeal within 63 calendar days of the date of the Notice of Reconsideration Resolution. We will send you a determination on your appeal within 30 calendar days of receiving the appeal. For online submissions: • Use the Availity Essentials Claim Status tool to initiate the appeal at **Availity.com**. Locate the claim you want to dispute using Claim Status from the *Claims & Payments* menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation and submit. To navigate directly to the initiated dispute in the appeals dashboard, add the documentation and submit. Please complete *the Claim Payment Appeal Form* (found on our website in the **Forms** section and submit a written payment appeal to: Payment Appeal Unit Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599 If you have exhausted the Healthy Blue payment appeal process and are still not satisfied with the resolution, you have the right to a state fair hearing with the Office of Administrative Hearings (OAH). Please see the ***State Fair Hearing*** section of this manual for more details.

If you have questions about. . .	Contact
Provider Grievances (non-claims grievances)	Providers can file a grievance within 180 calendar days of the incident. Submit verbal grievances to one of the following: • Provider Services at **833-838-2595** • Your local provider relationship account management representative Submit a grievance in writing by letter, fax, or email: Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599 Fax: **844-664-7183** Email: KansasProviderGA@healthybluekansas.com
Availity Registration	Register to use Availity Essentials, visit the **Availity Essentials & Support page**.
Availity Training	Visit the **Availity Learning Hub** to sign up for live and On-Demand courses with your Availity User ID and Password.

3. CLAIMS SUBMISSION PROCEDURES

You have the option of submitting claims electronically or by mail. We encourage use of electronic claims submission methods to help you:

- Receive explanations of payment and your reimbursements more quickly.
- Eliminate paper waste.
- Save time.

As a reminder, providers must use State of Kansas EVV Application used for the review and submittal of original claims for EVV Covered HCBS-PCS and Home Health Care Services (HHCS). Beginning January 22, 2025, this is the only approved method for original claims submittals for EVV Covered HCBS-PCS and Home Health Care Services (HHCS). Electronic Visit Verification PCS and HHCS visit codes can be found at **https://www.kancare.ks.gov/home/showpublisheddocument/1146/638576002343130000**.

KanCare Front-End Billing

For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. The Kansas Department of Health and Environment (KDHE) will submit your claim information to each managed care organization (MCO) through daily 837 batch files. Paper claims must be submitted directly to Healthy Blue. Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. EDI, including Electronic Remittance Advices (835), allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit **Availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway).

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions

on electronic response reports, contact your clearinghouse, billing vendor, or Availity at **800-AVAILITY (800-282-4548)**.

Availity EDI Payer ID: 00047
Payer IDs ensure your EDI submissions are routed correctly when received by Availity.

Availity's comprehensive Payer ID listing: **https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/**
Note: If you use a clearinghouse, billing service, or vendor, please work with them directly to determine payer ID.

Submitting Claims to Healthy Blue

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation. Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to Availity: **https://apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**.
3. Select **Enrollment Center** and select **Transaction Enrollment**.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic Funds Transfer (EFT)

Electronic claims payment through Electronic Funds Transfer (EFT) is a secure and fast way to receive payment, reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.

EDI Submission for Corrected Claims
For corrected electronic claims, use frequency code: 7 – Replacement of Prior Claim.

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation:
For details about EDI billing, refer to the *HIPAA* TR3s, the **Healthy Blue EDI webpage**, and the following resources:

- **Availity EDI Connection Service Startup Guide**: This guide includes information to get you started with submitting EDI transactions to Availity, from registration to on-going support.
- **Availity EDI Companion Guide**: This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

- **Availity.com**: Availity register page for users new to Availity.
- **Washington Publishing Company:** X12 code descriptions used on EDI transactions.

Paper Claim Submission

Healthy Blue encourages electronic claim submission; however, providers have the option to submit paper claims. Healthy Blue utilizes optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits of this technology include:

- Faster turnaround times and adjudication.
- Claims status availability within five days of receipt.
- Immediate image retrieval by staff for claims information, enabling more timely and accurate responses to provider inquiries.

In accordance with the implementation timelines set by CMS, the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC), Healthy Blue requires the use of the most current *CMS-1500* and *UB-04* forms.

Healthy Blue cannot accept claims with alterations to billing information. Healthy Blue does not accept computer-generated or typewritten claims with information that has been marked through, handwritten, or appears to have been covered by correction fluid or tape. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Please note: AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Paper and Electronic claims must be submitted within 180 days of the date of service for all services. The following cases are exceptions to the standard 180 calendar day filing limit:

- **Cases of coordination of benefits:** The time frames for filing a claim will begin on the date of the payment date recorded on the primary payer's *EOB*.
- **Cases of member enrollment in Healthy Blue with a retroactive eligibility date**: Healthy Blue will adjudicate any historical claims for the member even if the claims are past the 180-calendar day filing limit.

ICD-10 Coding System

International Classification of Diseases, 10th Revision (ICD-10), is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) used for diagnosis coding
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS replaced ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4, HCPCS, and ICD-10 manuals.

You must use *HIPAA*-compliant billing codes when billing Healthy Blue electronically or on paper. Providers must use the appropriate replacement codes for submitted claims whenever billing codes are updated. Claims submitted with noncompliant billing codes will be rejected.

CMS enforces correct coding through NCCI editing. Therefore, we reserve the right to utilize code-editing software to identify services that are considered part of, incidental to, or inclusive of the primary procedure.

Timely Filing

Providers should refer to their specific provider contract for timely filing periods. Generally, paper and electronic claims must be filed within 180 days. For any corrected claim, or other rebilling, the filing limit is 365 days from the date of service.

Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Timely filing requirements are defined in your provider agreement; please refer to it for detailed requirements.

There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits: For cases of coordination of benefits, the time frames for filing a claim will begin on the date of the payment date recorded on the primary payer's EOB.
- Cases where a member has retroactive eligibility: In situations of enrollment in Healthy Blue with a retroactive eligibility date, claims must be submitted within 180 calendar days from the eligibility determination date. Any claims submitted by both in-network and out-of-network providers beyond this timeframe will be denied due to untimely submission.

Documentation of Timely Claim Receipt

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- By U. S. mail (first class, return receipt requested or by overnight delivery service): the provider must provide a copy of the claim log that identifies each claim included in the submission.
- Electronically: the provider must provide the clearinghouse assigned receipt date from the reconciliation reports.
- By hand delivery: the provider must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant

- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Claims for Newborns

Claims for newborn services billed under the mother's member ID number may be suspended for 45 days pending our receipt of the newborn's member ID number from the state. If Healthy Blue receives a newborn ID within 45 days of the newborn's date of birth, the claim submitted under the mother's ID will be updated with the newborn baby's id and adjudicated.

If Healthy Blue does not receive a newborn ID within 45 days of the newborn's date of birth, the claim will be processed under the mother's member ID number.

Newborn services are considered procedure codes, which specifically state "newborn" in the code description, according to the CPT® manual or revenue codes 170-179 billed with a newborn diagnosis code.

When billing newborn services for a newborn that does not have a member ID number, providers must use "Newborn," "Baby Girl," or "Baby Boy" in the first name field and enter the last name. Providers must use the newborn's date of birth and the mother's member ID number.

Clean Claims Payments

A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

We will adhere to and adjudicate clean claims to a paid or denied status within:

- 100 percent of all clean claims, including adjustments processed and paid or processed and denied within 30 calendar days of receipt.
- 99 percent of all nonclean claims, including adjustments processed and paid or processed and denied within 60 calendar days of receipt.
- 100 percent of all claims, including adjustments processed and paid or processed and denied within 90 calendar days of receipt.

Nursing Facilities

We will adhere to and adjudicate clean claims to a paid or denied status as follows:

- Pay 90 percent of clean claims within 14 calendar days.
- Pay 99.5 percent of clean claims within 21 calendar days.

Healthy Blue will also provide technical assistance to Nursing Facility Providers for Claims submission.

Claims Status

You can check the status of claims on our provider self-service website (Availity Essentials) or by calling our Provider Services team. You can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.

If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

Coordination of Benefits and Third-party Liability

We follow Kansas-specific guidelines and all federal regulations regarding coordination of benefits, third-party liability (TPL) and medical subrogation.

TPL refers to any individual, entity, or program that may be liable for all or part of a member's health coverage. The state is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of each plan member.

Healthy Blue takes responsibility for identifying and pursuing TPL for our members. We will make best efforts to identify and coordinate with all third parties whose members may have claims submitted to Healthy Blue for payments or reimbursements for services.

Healthy Blue will make member TPL information available to providers through our web services.
Healthy Blue will participate in a supplemental recovery program for TPL. The state reserves the right to identify and recover any TPL identified more than six months after the day of payment of a claim.

The pay-and-chase circumstances are:

- When the services are for preventive pediatric care, including KAN Be Healthy (the Early and Periodic Screening, Diagnostic, and Treatment program).
- If the claim is for prenatal care.

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally. If you have any questions regarding paid, denied, or pended claims, please call Provider Services at **833-838-2595**.

The Provider's Role

Gathering Third Party Liability Information
Since you have direct contact with our members, you are the best source of timely third-party lability (TPL) information. The contribution you can make in the TPL area is very significant.

You have an obligation to investigate and report the existence of other insurance or liability. Cooperation is essential to the functioning of the Kansas Medical Assistance Program (KMAP) system and to ensure prompt payment. At the time you obtain billing information from the beneficiary, you should also determine if additional insurance resources exist. When they exist, these resources must be identified on the claim form in order for the claims to be adjudicated properly.

Remember, if a specific insurance coverage is on file for a member, proof of termination, denial, or exhaustion of benefits must be submitted from that carrier before the file can be corrected.

Billing TPL
Per 42 CFR §433.139(b), if the probable existence of TPL (such as Medicare or other health insurance) is established at the time a claim is filed, Healthy Blue must reject the claim and return it to the provider for a determination of the amount of liability. This means that the provider must attempt to bill the other insurance prior to filing the claim to Healthy Blue.

The provider must follow the rules of the primary insurance plan (such as obtaining prior authorization and filing within the primary insurance plan's timely filing period) or the related Healthy Blue claim will be denied. It is important that providers maintain adequate records of third-party recover efforts for a period of time not less than five years. These records, like all other records, are subject to audit by Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or any of their representatives.

Kansas requires member compliance with the rules of any insurance plan primary to KanCare. If the member does not cooperate and follow the rules of the insurance plan (such as staying in network, obtaining a referral, obtaining proper prior authorization), the related Healthy Blue claim will be denied. CMS does not allow federal dollars to be spent if a member with access to other insurance does not cooperate or follow the applicable rules of their other insurance plan. If a member has other applicable insurance, providers who bill electronic and web claims need to submit the claim adjustment reason code and remittance advice remark code provided by the other insurance company on their EOMB or RA for all affected services.

You must not bill Healthy Blue for the other insurance provider write-off amount (sometimes referred to as contractual write-off amount). Healthy Blue should only be billed for the remaining patient liability amount, if any.

When a service is not covered by a member's primary insurance plan, a blanket denial letter can be requested from the insurance carrier. From the insurance carrier, the provider needs to request a letter, on company letterhead, stating the service is not covered by the insurance plan covering the member.

You may not charge our members, or any financially responsible relative or representative of the member, any amount in excess of the Healthy Blue paid amount. Section 1902(a) (25)(C) of the Social Security Act prohibits Medicaid providers from directly billing Medicaid beneficiaries. Section 1902(g) allows for a reduction of payments otherwise due the provider in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

Long-Term Care Insurance
When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost-avoided.

If you discover an insurance policy that should have paid as primary to Medicaid after receiving payment from Medicaid, you must bill that insurance carrier and attempt to collect payment.

Healthy Blue cannot be rebilled if a claim has crossed over from Medicare to Medicaid, resulting in a zero-paid claim, because a zero-paid claim cannot be adjusted. When you allow a Medicare claim to cross over to Healthy Blue, you are agreeing to accept Medicaid payment as payment in full. In many cases, the claim will result in a zero Healthy Blue payment because Medicare's payment is greater than the Healthy Blue allowed amount. If you wish to pursue potential third parties after Medicare but before filing Medicaid claims, notify Healthy Blue that you do not want any Medicare claims to cross over. You can balance bill Healthy Blue, but you are not required to if Medicare and the other third-party payments received exceed the Healthy Blue allowed amount.

Medicare-related Claims

- When a patient is eligible for Medicare payment, providers must submit claims to Medicare first (unless the claim is for Medicare-exempt services). If a patient is 65 or over, has chronic renal disease, or is blind or disabled, an effort must be made to determine Medicare eligibility.
- You cannot seek to collect from a Healthy Blue member, or any financially responsible relative or representative of the member, the difference between the Medicare/Medicaid allowable and your billed charges (S.S.A.§1902(a)(25)(C).
- You should bill Medicare-noncovered and Medicare-covered services separately to ensure proper reimbursement. Medicare-covered services should be billed to Medicare and automatically crossed over.
- Services not covered by Medicare should not be billed to Medicare but instead directly to Healthy Blue or the other primary payer.
- If a clear determination cannot be made whether the resources are related to Medicare (including Medicare replacement plans or Part C Advantage Plans) or other health insurance, the claim will not be processed but will be returned requesting clarification.

Claims Automatically Crossed Over
Medicare Part B will automatically cross over claims for professional services when the following criteria are met:

- You file Medicare claims to the appropriate regional carrier for Kansas.
- The services are covered by Medicare.
- The member's Healthy Blue ID number is identified on the Medicare claim form in the "Other Insurance" field (Box 9a on the *CMS-1500* claim form).
- The "Accept Assignment" field (Box 27 on the *CMS-1500* claim form) is checked "yes."

You are notified on the *Explanation of Medicare Benefits* (*EOMB*) that the claim was automatically crossed over for Medicaid processing.

Claims Not Automatically Crossed Over

- Claims billed to Medicare carriers other than the appropriate regional Medicare contractor for Kansas
- Claims denied by Medicare
- Claims the fiscal agent is unable to find a provider number that cross matches

When this occurs, bill Healthy Blue by submitting a claim to us and attaching Medicare's *EOMB* or equivalent. In order for Medicare-related claims to process correctly, the Medicare *EOMB* attached to the claim must be specific to the member and match the codes and units.

Pricing Algorithm

- Healthy Blue processes professional and institutional Medicare-related claims using the same algorithm calculation applied to other third-party claims. If Medicare paid more than the amount allowed by Healthy Blue for that service, no additional reimbursement will be made. If a service is not covered under Healthy Blue, no allowable amount will be computed for the service.
- After calculation of the total amount allowed by Healthy Blue for the claim, comparison of what Healthy Blue allowed to the Medicare-allowed will be made (Medicare paid plus coinsurance plus deductible). Noncovered Medicare services and noncovered KanCare services are not included in this algorithm. These claims are processed using standard Healthy Blue pricing methodologies.
- When the amount allowed by Healthy Blue is greater than Medicare's paid amount (not including patient liability), Healthy Blue will make a payment. Healthy Blue will be the lesser of the:
  - Patient liability amount.
  - Difference between the amount allowed by Healthy Blue and the Medicare paid amount.

Exceptions to the Usual Pricing

When the amount allowed by Healthy Blue is equal to or less than Medicare's allowed amount, Healthy Blue will not make a payment unless the product or provider type has an exception to the usual pricing.

Rural health center, federally qualified health center, and Indian health center claims are exempt from the other insurance pricing algorithm applicable to other provider types. The lesser-allowed amount (Medicaid versus other insurance) should not be considered. Reimbursement should equal the Medicaid-allowed amount minus other insurance payment. This includes Medicare crossover claims as well. Note that the above disclaimer is not Medicare-specific but applies across other types of TPL as well.

If both Medicare Part A and B made payment on the same claim, the Medicare Part A payment is processed under the normal algorithm. The Part B payment should then be subtracted as other insurance payment.

Part B Only

When billing for members who have no Part A due to lack of eligibility or because benefits are exhausted:

- If the member has no Part A but does have Part B and is admitted to the hospital through the emergency room or outpatient department, these emergency room, outpatient, and selected inpatient

ancillary services must be billed to Medicare on form *SSA 1483*. Healthy Blue will process all Part A nonpayable services billed to Medicaid on the *UB-04* with appropriate documentation demonstrating Medicare's refusal to pay due to no Part A benefits.

- Payment must be made for members for all Healthy Blue covered services, less the Medicare-allowed amounts, spend down, copayment, and other third-party payments, but no more than the Healthy Blue maximum-allowable specified coinsurance and/or deductible amounts.
- Charges for emergency room or outpatient services are billed to Medicare on form *SSA 1483* for patients with Part B only. Healthy Blue will pay up to the maximum allowable for covered services, less the amount paid by Medicare, up to the deductible and/or coinsurance amount.
- If Part A Medicare benefits have been exhausted and the patient is still receiving care, bill Part B Medicare for inpatient benefits.
- Once Medicare Part A regular inpatient benefits are exhausted, dual-eligible beneficiaries (those who have both Medicaid and Medicare) can only receive Medicaid payment if they have already used their lifetime reserve (LTR) days or they elect to use their LTR days. A Healthy Blue member must make a written election not to use LTR days and cannot be “deemed” to have elected not to use LTR days. If a beneficiary makes a written election not to use LTR days after the regular inpatient days are exhausted, Healthy Blue will not issue payment for any part of the inpatient stay which would have been covered if the member had elected to use the LTR days.
- After making a written election not to use LTR days, a member can still decide to use LTR days. Healthy Blue will accept the written election form outlined by Medicare in Chapter 5 of the Medicare Benefit Policy Manual.

How to File When Medicare Denies Payment:

- Attach a copy of the Medicare EOMB/RA showing a denial of the service(s) being billed. If the services are over 12 months old, original timely filing must be proven. If services are over 24 months old, 12-month timely filing must be proven, and Healthy Blue must be billed within 30 days of Medicare's denial in order for claim payment to be considered.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by the member’s Healthy Blue plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.

- Recover and/or recoup claim payment.

The Healthy Blue reimbursement policies are based on state policies.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodologies are considered to be conditions of payments.

Review Schedule and Updates

Reimbursement policies will be made through state policy.

Medical Coding

The Medical Coding department ensures that correct coding guidelines as directed per state policy have been applied consistently through Healthy Blue. Those guidelines include but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes, etc.)
- Code editing rules, appropriately applied and within regulatory requirements.
- Analysis of codes, code definitions and appropriate use.

Healthy Blue-identified overpayments

Refund notifications may be identified by multiple entities: Healthy Blue and its contracted vendors, providers, and others. Healthy Blue researches and notifies the provider of an overpayment and may request a refund check or deduct the overpayment from a future payment. Once an overpayment has been identified by Healthy Blue or KanCare, they will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

Provider-identified overpayments

The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Providers are required to notify Healthy Blue of overpayments within 60 calendar days of identifying the overpayment. There are two options for providers to notify Healthy Blue should there be an overpayment of claims:

- **Refund Notification Form** — This is used if the provider wants to issue a refund check immediately. The provider would fill out the form and send it to the address listed along with a check.
- **Recoupment Notification Form** — This is used when the provider wants to alert us to an overpayment but doesn't want to issue a check immediately. The provider would fill this form out, send to the address listed, and then our recoupment department will review it and send the provider a recoupment request.

Both of these forms can be found on our website at **https://healthybluekansas.com/provider** under the *Forms* section.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *Affordable Care Act*.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective managed care organizations (MCOs) within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act* including treble damages. In order to avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments consistent with the requirements in the *PPACA*.

The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 *Fraud Enforcement and Recovery Act*. This provision of the *HealthCare Reform Act* applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Medicare Prescription Drug Program sponsors. It does not apply to members.

Outlier Reimbursement — Audit and Review Process

Audits/Records Requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation, and/or itemized bills related to claims for the purposes of conducting audit or reviews.

Blood and Blood Products

Blood and blood products such as platelets or plasma are reimbursable. Administration of blood or blood products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of blood or blood products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, and matching are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel

employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges

Charges for inpatient services for facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include but are not limited to lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions including IV or PICC line insertion at bedside, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient services for facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

Implants

Implants are objects or materials that are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore, or replace the function of an organ system or structure of the human body throughout its useful life. Implants include but are not limited to stents, artificial joints, shunts, pins, plates, screws, anchors, and radioactive seeds, in addition to non-soluble or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices, and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the member will not be reimbursed.

IV Sedation and Local Anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and are not separately reimbursable.

Labor Care Charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

Fees associated with nursing procedures or services provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include but are not limited to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time), and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges).

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, and pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to ***Routine Supplies*** section of the manual.

Personal Care Items and Services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush, and toothpaste.

Pharmacy Charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable, include but are not limited to IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

Portable charges are included in the reimbursement for the procedure, test, or X-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room Services Related to IV Sedation and/or Local Anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down). Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services
Items used for the patient that are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Examples include ICU and GI lab.

Standby Charges
Standby equipment and consumable items that are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment including but not limited to IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable.
In addition, oxygen charges including but not limited to oxygen therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bi-level positive airway pressure (BIPAP), when billed with room types ICU/CCU/ NICU or any Specialty Care area where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room ("OR")**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/Technical Anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room**: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post-anesthesia care unit ("PACU") record.
- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Charges for items such as batteries, covers, film, anti-fogger solution, and tapes are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

The disallowed charges (charges not eligible for reimbursement) include but are not limited to the following, whether billed under the specified Revenue Code or any other Revenue Code. These guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to member's benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Billing Members

Advance Beneficiary Notice

The KanCare member can be held responsible for payment of common services and situations. Members can be billed only when program requirements have been met and the provider has informed the member in advance and in writing. The provider must notify the member in advance if a service will not be covered. To ensure the member is aware of their responsibility, the provider must obtain a signed Advanced Beneficiary Notice (ABN) from the member prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable. An ABN form is available at the end of this section.

For services where there are normally no face-to-face contact points between the member and the provider (for example, lab and radiology services), the written ABN signed annually by the member with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

Providers are not to charge a member for services denied for payment by Healthy Blue because the provider failed to meet a program requirement, including prior authorization.

Members Held Harmless

Federal regulations stipulate that Medicaid members are not to be held liable for:

- The MCO's debts in the event of the entity's insolvency.
- Covered services provided to the members for which:
  - The state does not pay for the MCO.
  - The state or the MCO does not pay the individual or healthcare provider that furnishes the services under a contractual, referral or other arrangement.
- Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the services directly.

Advanced Beneficiary Notice Form

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are true:

- The member requests the specific service or item.
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

"I understand that, in the opinion of [provider's name], the services or items that I have requested to be provided to me on [dates of service] may not be covered under Healthy Blue as being reasonable and medically necessary for my care or are not a covered benefit. I understand that Healthy Blue has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Healthy Blue medically necessary standards for my care or are not a covered benefit."

Signature: _____

Date: _____

4. PROVIDER GRIEVANCES, RECONSIDERATIONS, APPEALS, EXTERNAL INDEPENDENT THIRD-PARTY REVIEWS, AND STATE FAIR HEARINGS

Provider Grievance Procedures

Submit verbal or written grievances within 180 calendar days of the incident; supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits.

You will not be penalized for filing a grievance.

Verbal Grievance Process

Submit verbal grievances to:

- Provider Services at **833-838-2595**.
- The Claims Grievance department **800-282-4548**.
- Your local provider relationship account management representative.

All provider calls will be answered during normal business hours. Call center representatives will verbally accept grievances. Most grievances will be resolved at the time of the call. Those grievances not resolved during the call, will be loaded and routed to the assigned provider relationship account management representative. Providers will be notified of the resolution within 30 calendar days of receipt. Most provider grievances will be resolved within 30 days, but all will be resolved within 60 days of receipt.

Written Grievance Process

Submit a grievance in writing by letter or fax to:

Provider Grievances
Healthy Blue
P.O. Box 61599
Virginia Beach, VA 23466-1599
Fax: **844-664-7183**

Claims Payment Inquiries

Our Provider Experience program helps you with claims payment and issue resolution. Call Provider Services **833-838-2595** and select the *Claims* prompt within our voice portal. Provider Services is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claims Correspondence versus Payment Appeal

The following table provides examples of claim related issues that should not go through the payment reconsideration or appeal process. These are common claim issues along with guidance on the most efficient ways to resolve the issue.

Type of Issue	What Do I Need to Do?
EDI rejected claim(s)	Contact Availity Customer Service at **800-AVAILITY (800-282-4548)** when your claim was submitted electronically but was never paid or was rejected. If you use an EDI Vendor, work with them to ensure you are receiving the response reports.
***EOP* requests for supporting documentation (Sterilization/ Hysterectomy/Abortion Consent forms, itemized bills, and invoices)**	Submit a claim correspondence form, a copy of your *EOP*, and the supporting documentation to: Claims Correspondence Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599
***EOP* requests for medical records**	Submit a claim correspondence form, a copy of your *EOP*, and the medical records to: Claims Correspondence Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a corrected claim using your EDI Vendor or though Availity Essentials, or submit a claim correspondence form and your corrected claim to: Claims Correspondence Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Healthy Blue to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a claim correspondence form, a copy of your *EOP*, and the COB/TPL information to: Claims Correspondence Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room payment review	Submit a claim correspondence form, a copy of your *EOP*, and the medical records to: Claims Correspondence Healthy Blue P.O. Box 61599 Virginia Beach, VA 23466-1599

Claim Payment Reconsiderations and Appeals

A claim payment reconsideration or an appeal is any dispute between you and Healthy Blue for reason(s) including:

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Retrospective review
- Disagreements over reduced or zero-paid claims
- Authorization issues
- Timely filing issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues

You will **not** be penalized for filing a reconsideration or appeal. No action is required by the member.

Claim Payment Reconsideration
Healthy Blue encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing an appeal.

We accept claim payment reconsideration requests in writing, verbally, and through our provider website within 120 calendar days (plus an additional three (3) calendar days to allow for mailing/sending) from the date on the *EOP*.

Healthy Blue will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. We will send you our decision in a Notice of Reconsideration Resolution, which will include:

1. The date of the notice.
2. The date the notice was sent.
3. The action that Healthy Blue has made or intends to make.
4. The results of the resolution process.
5. The date of the Reconsideration Resolution.
6. An explanation of the medical basis for the decision, application of policy, or accepted standards of medical practice to the individual's medical circumstances, if the action is based upon a determination that the service is not medically necessary.
7. The statute, regulation, policy, or procedure supporting the action, if the action is based upon a statute, regulation, policy, or procedure.
8. An explanation of the provider's right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
9. The procedures by which the provider may request an appeal.
10. The provider's right to represent themselves or be represented by legal counsel or another spokesperson.
11. The specific change in federal or state law that requires the action.

12. The provider's right to a state fair hearing following the completion of the provider appeal process.

Note: If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

If additional information is required to make a determination, the determination date may be extended by 14 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Appeal
If you are dissatisfied with the outcome of a claim's payment reconsideration determination or if you wish to bypass the reconsideration process altogether, you may submit a claim payment appeal.

We accept claim payment appeals through Availity Essentials or in writing or within 63 calendar days of the date of the *EOP* if no reconsideration was requested previously; or if a reconsideration was requested, within 63 calendar days of the date on the notice of reconsideration resolution.

Claim payment appeals received more than 63 calendar days after the *EOP* or the notice of reconsideration resolution, will be considered untimely and will be upheld. The Notice of Provider Appeal Resolution will include:

1. The date of the Notice of Provider Appeal Resolution.
2. The date the Notice of the Provider Appeal Resolution was sent. If the notice is in the form of a remittance advice (RA), the sent date may be represented by the date on the RA that indicated it is available electronically.
3. The results of the resolution process and the date of the appeal resolution.
4. The date the appeal was received.
5. For decisions not wholly in the provider's favor:
    a. A statement that the provider's appeal rights within the Healthy Blues' appeal process have been exhausted.
    b. A statement that the provider is entitled to an External Independent Third-Party Review.
    c. The requirements to request an External Independent Third-Party Review.
    d. An explanation of the provider's right to request a state fair hearing following receipt of Healthy Blues' Notice of Provider Appeal Resolution.
    e. A statement of the provider's claim payment appeal request.
    f. A statement of what action Healthy Blue intends to take or has taken.
    g. The reason for the action.
    h. A statement about how to submit a state fair hearing.
    i. Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.

Note: If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Healthy Blue professionals.

If the claim payment determination requires additional information to resolve, the determination date may be extended by 14 calendar days. A written extension letter will be sent to you before the expiration of the initial 30 calendar-day claims appeal determination period.

How to Submit Reconsiderations, Appeals, External Independent Third-Party Reviews and State Fair Hearings

Verbal submissions (reconsiderations only)
Submit reconsiderations verbally by calling Provider Services at **833-838-2595**.

Secure Provider Website Submissions (both reconsiderations and appeals)
Healthy Blue can receive reconsiderations and appeals via the Availity Essentials Appeal tool at **Availity.com**. To submit a reconsideration or appeal online:

1. Under the Claims & Payment Manu, select **Claim Status**.
2. Complete the *Claim Status Inquiry* and select the claim you wish to reconsider or appeal.
3. Select **Dispute Claim** near the top of the screen to initiate the appeal.
4. Select **Go to Appeals** to be navigated to the Appeals tool to locate your initiated appeal, upload document(s), and submit the appeal.

If the web option is chosen, you will receive immediate acknowledgement and updates of your submission in the Availity notifications once the form is fully completed. If a provider wishes to bypass the reconsideration step and file an appeal, please note this in the text box.

Written Submissions (both reconsideration and appeals)
Mail written reconsiderations and appeals, along with the *Claim Payment Appeal Form* or the *Reimbursement Reconsideration Form* to:

Payment Appeals
Healthy Blue
P.O. Box 61599
Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Reconsideration and Appeals Submissions
Healthy Blue requires the following information when submitting a claims payment reconsideration or appeal:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Healthy Blue or Medicaid ID number
- A listing of disputed claims, which should include the Healthy Blue claim number and the date(s) of service(s)
- Supporting statements and documentation

Submit written appeals on the *Claim Payment Appeal Submission* form located at: **https://healthybluekansas.com/provider**. Submit claims payment reconsiderations on the *Reimbursement Reconsideration Submission* form located at: **https://healthybluekansas.com/provider.**

External Independent Third-Party Reviews (EITPR)

If you do not agree with this decision, you have the right to request an external independent third-party review. The request must be received in writing on the Healthy Blue EITPR form located at: **https://healthybluekansas.com/provider** and within 63 calendar days from the date of the appeal resolution notice. We will notify you when we receive your request.

Only the records and documentation reviewed during the appeal will be reviewed during the EITPR. Additional documentation will not be accepted with the EITPR request; providers must use the Healthy Blue EITPR Request Form to submit a request. We will send the documents submitted by the provider during the appeal process to the external reviewer.

Your request will be reviewed within 30 days from receipt.

You may submit your External Independent Third-Party Review request form by fax to **877-881-1305** or mail.

Healthy Blue
Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

Claims Related to Medical Necessity

Prior authorization appeals should be submitted within 60 calendar days of the date of the Healthy Blue denial letter. An additional three calendar days is allowed for mailing time. These denials should be appealed prior to claim submission.

Healthy Blue will abide by the determination of the physician resolving the dispute. You are expected to do the same. We will ensure the physician resolving the dispute will hold the same specialty or a related specialty as the appealing provider.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

State Fair Hearing Rights

Providers have the right to file a state fair hearing within 123 calendar days of the date on Healthy Blue's notice of appeal resolution regarding denials of payment or service. Providers also have the right to file a state fair hearing within 33 calendar days of the date on Healthy Blue's notice of external reviewer decision. KDHE

requires providers exhaust all levels of MCO grievance and appeal processes before seeking state fair hearings. Once all MCO levels of the grievance and appeal are exhausted, providers have full access to the state fair hearing process. Providers have the right to file a state fair hearing for (1) denials of payment for services a*fter the services were rendered* in cases where there is no member liability or (2) after denials of a new service.

State Fair Hearing Process for Providers

Once providers have exhausted the grievance and appeal process, they may submit a request for a state fair hearing. The request must be received within 120 calendar days of the date of the letter with our final decision on your appeal, plus an additional three calendar days to allow for mailing/sending.

Providers may file state fair hearing requests with the **Office of Administrative Hearings**. You may fax the request to **785-296-4848** or mail it to:

Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327

Please provide the following information when submitting a state fair hearing request:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Healthy Blue or Medicaid ID number
- The specific reason for the hearing including the claim number and the date(s) of service(s), or both of the following:
  - The denied service and the date of the notice of appeal
  - The Healthy Blue appeal number

5. PROGRAM OVERVIEW, BENEFITS AND LIMITATIONS

KanCare Programs Description

Healthy Blue is one of the participating MCOs providing services to KanCare members statewide.

KanCare is the Medicaid and Children's Health Insurance Program (CHIP) managed care program that integrates physical health, behavioral health, and pharmacy services. The program also includes certain long-term services and supports (LTSS), home- and community-based services (HCBS), and other program offerings for the following populations:

- Medically Needy Parents and Other Caretaker Relatives
- Pregnant women
- Newborns
- Foster care children
- Children from families receiving adoption support
- Children eligible for the Children's Health Insurance Program (CHIP)
- Those receiving Supplemental Security Income (SSI)
- Those who are not yet determined disabled by Social Security
- Elderly population
- Those who are eligible for the Working Healthy program
- Those dually eligible for Medicare and Medicaid
- Those meeting the criteria for intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or nursing facilities
- Those participating in Medicaid via the Spenddown program
- Those participating in waivers, including:
  - Technology Assisted Waiver
  - Autism Waiver
  - Serious Emotional Disturbance (SED) Waiver
  - Physical Disability Waiver
  - Frail Elderly Waiver
  - Brain Injury (BI) Waiver
  - Intellectual/Developmental Disability (I/DD) Waiver

Covered Benefits through Healthy Blue

So that you, as a provider, see the benefit information our members see, the covered services information below closely mirrors the information found in our member handbook.

We do not cover experimental procedures or medications unless specifically noted below.

Healthy Blue maintains a benefit package and procedural coverage for members at least as comprehensive as the Medicaid state plan.

KanCare members have no copays for covered services. Members with unmet spenddown may have out of pocket costs to meet their spenddown deductible before their KanCare benefits begin. Some services require prior authorization. Common benefits and services include the below (**benefits may be limited based on member's eligibility group or age**):

- Allergy services
- Ambulance (emergency – must be medically necessary)
- Ambulatory surgical center
- Asthma education
- Audiology services
- Behavioral health and substance use disorders (including emergency)
- Birthing center (covered for pregnant members)
- Cancer screenings
- Chronic pain management
- Dental services
- Diabetes Prevention Program (DPP) services
- Durable medical equipment (DME)
- Emergency medical and post-stabilization services
- Family planning (sterilizations not covered for members under age 21)
- Hearing aids
- Home health services
- Hospice care
- Inpatient hospital services
- KAN Be Healthy (EPSDT — Early and Periodic Screening, Diagnosis, and Treatment)
- Laboratory diagnostic and radiology services
- Mammogram
- Maternity care, including a certified nurse midwife
- Non-emergent transportation services, including to medical appointments
- Outpatient hospital services
- Personal care services
- Pharmacy
- Podiatry services
- Preventive services
- Physician services
- Prosthetic devices
- Social health resources (food, employment assistance, housing, transportation)
- Therapy — physical, speech, occupational Tobacco cessation counseling
- Urgent care services
- Vision services

KanCare members may obtain the following services through Healthy Blue or a local health department:

- Immunizations
- Screening and testing for HIV
- Screening, testing, and treatment for lead poisoning

- Screening, testing, and treatment for sexually transmitted infections
- Screening, testing, and treatment for tuberculosis

Healthy Blue Value-Added Benefits

Healthy Blue covers extra benefits that eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added benefits. Certain rules and restrictions may apply.

Members receive detailed information about how to access these services in their member handbooks, on **https://healthyblueks.com**, or by calling Member Services for more information.

If you have questions about how to help a member with these services, call Provider Services for assistance at **833-838-2595**.

Benefit/Services	Description
Asthma Relief Catalog	Members with asthma or COPD can select up to 2 items per year ($200 max) from a custom catalog of asthma and allergy relief products from options such as: inhaler vaporizer kits, air purifiers, travel nebulizer compressor systems, hypoallergenic bedding, pillow covers and mattress covers, HEPA air filters, and asthma monitoring devices to manage symptom triggers and prevent asthma attacks.
Baby Essentials	Pregnant members that complete a postpartum visit can receive $100 to purchase items that support a healthy environment for baby and birthing recovery, such as: • Baby monitor • Baby proof items • Convertible car seat • Diapers • Highchair • Portable crib
Baby on the Way	Available to pregnant members who complete a prenatal visit in the first trimester. Eligible pregnant members can receive a $100 gift card per pregnancy to purchase items that support a healthy pregnancy and healthy environment for baby, such as: • Folic acid supplements • Maternity support belts and hose
Clothing Essentials	Foster care members and children in a kinship placement can receive a $50 gift card per year to purchase clothing for members to retailers such as Kohl's, TJ Maxx, or Old Navy.

Benefit/Services	Description
Community Transportation	Members can get up to 30 roundtrip rides per year to cover for example: grocery stores, food banks, places of worship, WIC appointments, prenatal classes, lactation consultants, breastfeeding and postpartum support groups, the pharmacy, job interviews, career coaching courses, shopping for work attire, community health events, and more.
Dental Desensitization Kit	Members on the I/DD waiver with sensory or dental anxiety can receive one dental desensitization kit per year to help reduce anxiety and stress.
e-Reader	Foster Care eligible, and members on the I/DD, Autism, and SED Waivers are eligible to receive an e-reader that can be used to read books, watch movies, listen to podcasts, and more. (One-time benefit)
Emotional Well-Being Program	Eligible members receive unlimited access to the online community which promotes behavioral health and wellness through instruction, coaching, goal setting and monitoring. These self-help resources ensure members can actively participate in their journey to becoming and staying mentally and physically healthy. Resources include: • Access to on-demand personalized self-paced online programs with interactive multi-media tools and activities, and the ability to track progress • Opt-in support from a Masters-level clinical coach by phone, email, or text to further their emotional well-being goals • The ability to engage family and friends in their experience to provide ongoing encouragement Free webinars on a variety of emotional well-being topics Members can use the platform to get support when they need it and practice skills that improve conditions in ways that promote overall good health.
Employment Basics Support Package	Members 18 and older enrolled in the Job Connections program can select one of the following items to support their employment goals: • GED assistance • Industry certification assistance • Uniform support • Styling support • Tools Benefit is limited to one selection per member per lifetime.
Family Night Package	Youth in Foster Care and kinship families can choose from one of the following per year: Family Game Night package includes a card game, jumbo playing dice, jigsaw puzzle and a classic board game, Family Movie Night - a $50 Fandango gift card, or Family Dinner Night - a $50 restaurant gift card.

Benefit/Services	Description
Free Diapers	New moms who complete their child's first well-child visit can receive one package of diapers each quarter until the age of 1, up to 800 diapers.
Fresh Food Connect	Members over 18 with a behavioral health diagnosis can receive up to a $75 Healthy Grocery Store gift card or wholesale membership access for healthy and nutritious food options. Max one gift card, 3 boxes of fresh produce or one wholesale membership per household.
Get Connected to Health Program	Members assigned a case manager are eligible for the Get Connected to Health program and can receive a high-quality smartphone that's preloaded with a curated selection of digital health applications and resources designed to help them quickly access care and stay healthy. This enhanced offering provides members with a higher-quality phone at no cost with unlimited minutes, text messages, data, and accessories.
Healthy Adults Healthy Results	Members 18+ diagnosed with hypertension or diabetes are eligible for our Healthy Adults, Healthy Results Program, which includes: • On-demand fitness and exercise resources designed to help teach the importance of physical activity • Personal Exercise Kit or $50 toward a gym membership • Weight Watchers membership • $50 Healthy Grocery Card
Healthy Grocery Card	Eligible pregnant members receive one $75Healthy Grocery Card per pregnancy.
Healthy Home	Healthy Blue Members on the I/DD, PD, FE, BI waivers or the waiver waiting lists who own their own home can receive up to $250 toward pest control treatments or carpet cleaning services.
Healthy Lifestyle Aids	Waiver members and members diagnosed with coronary artery disease (CAD), congestive heart failure (CHF), hypertension (HTN), or diabetes can select up to 2 healthy lifestyle aids (not to exceed $75), such as a digital scale, diabetic insoles and socks, reachers/grabbers, raised toilet seats, fitness trackers, large button remotes, abdominal binders, lumbar support items, memory foam pillows, and more.
Home Safety	FE, PD, and I/DD waiver members can select up to 2 home safety items per year such as: carbon monoxide detectors, hearing impaired smoke alarms, fire extinguishers, air quality monitor, water filtration kits, gun locks, radon detectors, night lights, door alarms, or mold tests.
Identification Support	We will cover the cost of obtaining a driver's license, birth certificate, or state identification card for members age 14 and older who do not have access to these resources through another source. (One-time benefit.)
Living within the Community Training Incentive	Healthy Blue members on the FE, PD, I/DD, and BI waivers or the waiver waiting lists that complete the "Living Well in the Community" training courses

Benefit/Services	Description
	offered by Three Rivers, Inc. (3Rivers) Center for Independent Living will receive up to $50 in gift cards for successful completion of the full curriculum.
Meditation App Subscription	Members age 13 and up with a behavioral health diagnosis will receive access to a yearly subscription to a Meditation App with guided meditations, sleep aids, and other resources to promote mindfulness and reduce stress.
Nursing Support Items	Pregnant and new moms can receive a $75 gift card to purchase items to help support healthy breastfeeding such as a nursing support pillow, disposable nursing pads, extra milk storage bags and bottles, nursing cover, microwave sterilizer, and more.
Online Enrichment Classes	Youth in Foster Care ages 5–18 will receive a $75 gift card per year for online classes that offer a variety of engaging, small-group classes online to explore their interests in depth via interactive, live video by experienced, independent educators.
Online Enrichment Classes	Members enrolled in case management with substance use disorders will receive access to our SUD Recovery Support Program, a mobile platform that provides daily motivations/check in, peer support through discussion groups and peer to peer messages, counselor messaging, care plan reminders, goals, journals, high-risk location alerts, and content to support ongoing recovery.
Over-the-Counter and Personal Care Items	Members can receive up to $25 per household per quarter to purchase: • OTC items, such as pain relievers, nasal decongestants, nutritional supplements, sleep aids, incontinence products, and more • Personal hygiene items, such as feminine products, shampoos, conditioners, deodorants, toothbrush holders, hair combs/brushes, and facial tissues.
PO Box Access	Post office boxes (P.O. Box) benefit Tribal Members by enabling them to receive mail in areas where mail may not be delivered directly to their homes. The benefits of P.O. boxes include security, privacy, the need for quicker delivery, and to maintain a permanent mailing address. Healthy Blue will pay for one year of (of a size small) post office box. (One-time benefit.)
Post-Secondary Education Support	Eligible members in 12th grade are eligible to receive up to a $75 gift card once per lifetime to use toward textbooks and dorm room items.
Sensory Solutions	Members on the IDD, Autism, and SED waivers or with a diagnosis of ADD, ADHD, or anxiety are eligible to receive a $100 allowance per year to choose from custom textile products, equipment, toys, and other tactile and sensory products like gravity blankets, thinking putty, fidget spinners, and resistance bands. These products are meant to help improve conversation building and fine motor skills, help reduce anxiety, improve focus, and more!

Benefit/Services	Description
Summer Camp	Youth members, ages 5–17, that complete a well-child visit can receive up to $200 to help cover the costs for summer camp.
Transportation Essentials	Members 18 and up that complete a wellness visit will be able to receive one of the following with a value up to $75 per member per year: • Ride share gift card • Gas card • Oil change • Public transportation
Youth Club Membership	Eligible members, ages 5–18, receive a $75 gift card per year to use toward annual membership fees to youth clubs, such as: Boys and Girls Clubs, YMCA, Girl Scouts, Boy Scouts, and 4H.

Blood Lead Screening and Testing

You should use clinical judgement and the **KAN Be Healthy (KBH) - EPSDT Blood Lead Screening Questionnaire** when screening for lead toxicity. However, in order to comply with federal government requirements, you must perform a blood lead test on members by 12 months and 24 months of age to determine lead exposure and toxicity. You should also give blood lead tests to children older than 24 months up to 72 months if you have no past record of a test.

Financial Management Services

Financial management services (FMS) are provided for KanCare members who are aging or disabled. According to Kansas state law (K.S.A. 39-7,100), members have the right to self-direct. Self-direction is defined as making decisions about, directing the provisions of and controlling the personal care services (PCS) received including but not limited to selecting, training, managing, paying, and dismissing of a direct support worker. The member or their representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a system of available supports. FMS is included in these supports.

Services in support of member-direction are offered whenever a waiver affords members the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (1) information and assistance in support of member direction and (2) financial management services

For HCBS services, FMS services require a prior authorization through the plan of care (POC) process.

All HCBS FMS providers must enroll and receive a provider number for HCBS services.

All claims for FMS must be submitted through the EV&M system, AuthentiCare Kansas, web application.

All FMS providers are expected to follow the requirements outlined within the FMS manual For more information, we suggest the following references:

- **Self-Direction | Department for Aging and Disability Services (ks.gov)**
- **KANSAS (kmap-state-ks.us)**

FMS Eligibility
FMS is available to members who reside in their own private residences or private homes of family members whom the state has determined are eligible for specific waiver programs and have chosen to self-direct some or all of their services. The member or their representative has the right to choose this model and qualified available FMS providers. The administrative functions of the FMS provider are reimbursed as waiver services.

Immunizations

If you are authorized to prescribe vaccines, we strongly encourage you to enroll in the **Vaccines for Children (VFC)** program administered by KDHE. Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices schedule. You must report all immunizations of children up to age 2 to the Kansas web immunization registry (Kansas WebIZ). If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products, or other products that are available free of charge from Kansas WebIZ; we only cover the administration fee for members ages 18 and younger. Since VFC only covers serum for children ages 18 and younger, Healthy Blue pays for these vaccines for our 19- and 20-year-old members under the medical benefit.

Our members can self-refer to any qualified provider in or out of our network.

Pharmacy Services

Healthy Blue is responsible for prescription drug coverage for our members enrolled in Medicaid through Healthy Blue in Kansas. Some Healthy Blue members may have drug coverage through Medicare that is not managed by Healthy Blue, and we can help coordinate that coverage. Healthy Blue manages the pharmacy benefit through our pharmacy benefits manager, CarelonRx, Inc. Members must use an in-network pharmacy for prescription services so that they are not subject to unnecessary out of-pocket costs.

Healthy Blue has contracted with CarelonRx to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online real-time access to member eligibility, drug coverage (including prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review. Pharmacy providers in the Healthy Blue pharmacy network should submit pharmacy benefit claims to CarelonRx for members. Pharmacies may dispense up to a one-month supply of medication.

Formulary and Preferred Drug List

Healthy Blue follows the Kansas Medical Assistance Program (KMAP) drug formulary and Preferred Drug List (PDL). The KMAP formulary is a complete list of covered outpatient drugs under the pharmacy benefit. This list

contains brand name and generic drugs which meet the CMS definition of a covered outpatient drugs and are considered safe, efficacious, and are eligible for drug rebate.

The Kansas PDL is a subset of the Kansas formulary. It is comprised of certain drug classes from the formulary that have been identified as an opportunity to encourage clinically appropriate use while promoting cost saving without sacrificing the quality of care. Based on clinical data, the State PDL Committee reviews these drugs classes to determine if any drug in the class is clinically superior. If the drugs are considered clinically equivalent, then KMAP assigns the Preferred and Non-Preferred drug status for each drug in the PDL drug class to promote cost savings. The non-preferred products will require the member to try the preferred drugs as described in the Non-preferred drug prior authorization criteria approved by the KMAP Drug Utilization Review Board (DUR).

The Healthy Blue pharmacy benefit provides coverage for medically necessary medications from any licensed prescriber for legend and non-legend medications that appear in accordance with KMAP's latest revision of the Kansas formulary and PDL for Medicaid. All managed care plans and the fee-for-service program serving KanCare follow the KMAP PDL. The PDL may be found at **Preferred Drug List | KDHE, KS**.

After the PDL Committee and DUR Board recommendations are made and published in Kansas policy, new prescriptions for the nonpreferred drugs will require prior authorization. As other therapeutic drug classes are evaluated by the PDL Committee and the DUR Board, Healthy Blue will publish the KDHE Provider Bulletin information on the provider portal. Additionally, KMAP Provider Bulletins may be found at **Bulletins (kmap-state-ks.us)**.

E-Prescribing

Healthy Blue supports e-prescribing technologies to communicate the KMAP PDL and formulary drug lists to prescribers through electronic medical records (EMRs) and e-prescribing applications. Healthy Blue encourages the utilization of e-prescribing technologies to ensure appropriate prescribing for members based on the member's plan. Much of the e-prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies.

Pharmacy Prior Authorization

Healthy Blue uses the KMAP prior authorization (PA) criteria that has been reviewed and approved by the KMAP DUR Board. Our PA system will be programmed to utilize only Kansas PA criteria. Providers may submit a PA request through electronic PA (e-PA), fax, or phone to Healthy Blue.

Electronic prior authorization (ePA) is available through CoverMyMeds. This PA method saves time; submitting ePA requests is faster than phone/fax requests, and there is no paperwork to manage. Providers may visit the CoverMyMeds website (**covermymeds.com**) through their electronic medical records tool and use the ePA functionality if it exists.

Healthy Blue PA requests will be processed in 24 hours. A letter of notification of the PA decision will be sent to the provider electronically or via fax. The member will be mailed the decision letter immediately after the decision is rendered.

Prescribing providers must review the KDHE Prescription Drug Monitoring Program website **https://www.kdhe.ks.gov/1997/Prescription-Drug-Monitoring-Program** Before prescribing controlled substance to members.

Pharmacy Benefit PA:

- Electronic PA (e-PA) via CoverMyMeds (**covermymeds.com**)
- Fax: **877-941-9901**
- Phone: **833-838-2595**

Physician Administered Drugs PA Medical Benefit:

- Electronic PA (e-PA) via CoverMyMeds (**covermymeds.com**)
- Fax: **877-941-9841**
- Phone: **833-838-2595**

KMAP PA criteria may be found at **General Clinical Prior Authorization | KDHE, KS**.

KMAP PA forms may be found at **Clinical-PA-Drug-Index-PDF (ks.gov)**.

Emergency Pharmacy PA

When medications are needed without delay (emergent situations) and PA is not available, a 72-hour supply for non-mental health medications or a five (5)-day supply for mental health medications must be authorized, until a PA can be secured. The pharmacy is to call the Pharmacy helpdesk **833-838-8802** for a one-time override.

New to Market Drugs

As new drugs enter the market, they may be subject to the KMAP Advanced Medical Hold PA criteria until the DUR Board can review and approve clinical PA criteria for the specific drug. Providers should check the Clinical PA Drug Index for the new to market drug. If the drug isn't listed, then the Advanced Medical Hold criteria will apply **Advanced Medical Hold Manual Review | KDHE, KS**.

Maximum Days' Supply

Healthy Blue follows the KMAP maximum days' supply limits. A mandatory 3-month (90-day maximum) supply fill policy is in place for medications included on the Kansas Department of Health and Environment (KDHE) **90-Day-Maintenance-Drug-List-PDF (ks.gov)** on the KDHE website. For all other medications, a one-month supply (31-day maximum) of medication per prescription must be dispensed at one time unless otherwise limited by KMAP. Exceptions to this rule are listed in the KMAP Pharmacy Provider Manual **Provider Manuals (kmap-state-ks.us)**. This criterion is for all pharmacy providers including those servicing adult care homes. Unauthorized reduction of prescription quantities is considered prescription splitting and is not allowed.

Drug Limits

Healthy Blue follows the drug limits (for example, quantity, maximum daily dose, and Morphine Milliequivalents [MME]) of the KMAP Pharmacy benefit.

If a prescribing provider feels a quantity supply greater than the defined maximum is medically necessary, a PA request must be submitted to validate the medical rationale for exceeding the recommended dosage.

340B Program

Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain facilities and groups like federal grantees, FQHCs, FQHC look-alikes, and qualified disproportionate share hospitals. This enables these entities to purchase 340B drugs at discounted rates and optimize federal resources.

Covered Entity Pharmacies (excludes contracting pharmacies) that are listed on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File and fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act, will be required to bill Medicaid.

Contract Pharmacies should not dispense drugs acquired through the Federal 340B drug price program to Medicaid patients. Contract Pharmacy claims will be included for drug rebate. For additional 340B Program and Kansas Medicaid information, visit the **340B Program & Kansas Medicaid | KDHE, KS**.

Mandatory Generic Drug Policy

Generic substitution for multi-source brand-name drugs is required. Generic drugs must be provided when available. When a generic drug is available, brand-name products will only be approved through prior authorization. If a prescriber specifies dispense as written (DAW) on a drug which has a bioequivalent generic substitute available, a Brand Medical Necessity PA request approval is required for reimbursement of the brand product. See the Brand-Medical-Necessity PA criteria for more details and exceptions: **Brand Medical Necessity PA form**. See the KS PDL for exceptions: **Preferred Drug List | KDHE, KS**.

Pharmacy Copays

Healthy Blue members do not have copays for their pharmacy benefit. Additionally, Healthy Blue provides copay assistance to members who have both full Medicare Part D entitlement and: Title XIX Medicaid (TXIX) or Medical needy with no spenddown or spenddown has been met. Exception: Members with unmet spenddown will be charged a copay until their spenddown is met. Some exceptions apply.

Medication Therapy Management

Healthy Blue members may be offered Medication Therapy Management (MTM), a program designed to work closely with providers, pharmacists, and members to provide additional assurances that the prescribed medications are safe, effective, and being utilized appropriately. Members meeting the criteria for the program receive written information about the program and have the opportunity to opt in or out of the program.

In our MTM program, members who are taking five or more medications and have two or more chronic conditions may be offered opportunities to speak directly to a Kansas-licensed pharmacist about their medication use. The pharmacist will perform a complete review of the member's medication use and make recommendations for improving medication safety, improving effectiveness, and reducing costs. These recommendations will be shared with the member's PCP.

Mail order

Healthy Blue members may use a mail order pharmacy to obtain their prescriptions. They are limited to a 31-day supply for most drugs. For maintenance drugs, members who have received more than 90 days' supply of a **state-defined maintenance drug** in the past 180 days are required to receive a 90-day supply per fill. Members may also receive a 90-day supply of maintenance medication through a retail pharmacy. (Specialty medication is not eligible for a 90-day supply.)

Members residing in nursing or assisted living facilities are exempt from this requirement.

Excluded Drugs

The following are excluded from the pharmacy benefit:

- In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8: any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program
- Drug products that are classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8 suchas:
  - Drugs used for cosmetic reasons or hair growth
  - Drugs used for experimental or investigational indication
  - Infertility medications
  - Erectile dysfunction drugs to treat impotence
- Non-legend drugs other than those listed above or specifically listed under covered non-legend drugs

Non-covered is not the same as prior authorization required. Non-covered drugs are those that are excluded from benefit coverage.

DME Items Commonly Supplied by a Pharmacy — Billed Under Medical Benefit

The following DME items commonly supplied by a pharmacy must be billed under the medical benefit (must bill Healthy Blue):

- Vaccines
- Diabetic test supplies
- Nutritional supplement (for example, Ensure©)
- Spacers (for example, AeroChamber©)
- Thickening agents (Thick-It©)

Physician-administered Drugs

Claims for physician-administered medications should be submitted to the medical benefit with a *CMS-1500* form and include a procedure code and an NDC.

Healthy Blue allows reimbursement for drug claims received with HCPCS/CPT codes that do not contain medically unlikely edit (MUE) limits and are within the physical quantities of drugs (also known as units) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Drug claims must be submitted as required with applicable HCPCS or CPT code(s), national drug codes, appropriate qualifier, unit of measure, number of units, and price per unit. Units should be reported in the multiples included in the code descriptor used for the applicable HCPCS codes.

Reimbursement will be considered up to the clinical unit limits (CUL) allowed for the prescribed/administered drug. Healthy Blue utilizes the CMS MUE value. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or be calculated based on the prescribing information, the FDA, and established reference compendia.

Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied.

New Baby, New Life℠ Pregnancy Support Program

New Baby, New Life℠ is a proactive case-management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include state enrollment files, claims data, and hospital census reports as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced care coordinators work with members and providers to establish a care plan for our highest risk pregnant members. Care coordinators collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our pregnant and postpartum members to take part in our New Baby, New Life program, a comprehensive case management and care coordination program which offers:

- Individualized, one-on-one care management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the New Baby, New Life program, perinatal members have access to a digital maternity program. The digital offering provides pregnant and postpartum members with timely, proactive, and culturally appropriate education via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screening. The answers provided in the screening allows Healthy Blue to assess their pregnancy risk.

After risk assessment is complete, the digital program delivers gestational age-appropriate education directly to the member. This digital offering does not replace the high-touch, individual care management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Healthy Blue to identify members who experience a change in risk acuity throughout the perinatal period.

We request notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity Essentials or fax the forms to Healthy Blue at **800-964-3627**.

We encourage healthcare providers to share information about the New Baby, New Life program and the digital maternity tools offered by Healthy Blue with members. Members may access information about the products that are available by visiting the Healthy Blue member website.

For more information about the New Baby, New Life program or the digital maternity tools, reach out to your OB Practice Consultant or refer to our website at **https://www.healthybluekansas.com/provider**. After the baby is born, we encourage our providers to reference the Bright Futures Guidelines, developed by the American Academy of Pediatrics, for the latest guidance on pediatric preventative services.

NICU Care Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Case Management program.

We extend our support by helping parents to prepare themselves and their homes for when the baby is released from the hospital. After the baby is home, our care coordinators continue to provide education and assistance in improving the baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs.
- Facilitating parent screenings for potential PTSD.
- Connecting parents with behavioral health program resources and community support as needed.
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped.

For more information about our NICU Case Management program, refer to our website at **https://www.healthybluekansas.com/provider**.

6. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

Utilization Management Program

Our utilization management (UM) program facilitates the delivery of the most appropriate medically necessary care, benefits, and services to our eligible members in the most appropriate setting while ensuring our members receive clinically appropriate care and services in the most efficient manner possible.

For services that require prior authorization, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria.

The UM program includes activities related to inpatient and ambulatory care. Through collaboration with other programs within the health plan such as care coordination, discharge planning, and community programs, we ensure we meet the physical, behavioral, and social needs of our members.

We provide medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior healthcare services. For members who qualify, we also provide functionally necessary community long-term services and supports beginning on the member's date of enrollment, regardless of health status, pre-existing conditions, prior diagnosis, receipt of any prior healthcare services, confinement in a healthcare facility, and/or previous coverage, if any, or the reason for termination of such coverage. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

Regarding UM issues, staff are available at least eight hours a day Monday through Friday 8 a.m. to 5 p.m. Central time for inbound or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within one business day. Our staff will identify themselves by name, title, and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

The Kansas Medicaid Universal Prior Authorization Form, Medical Policies, and UM Criteria can be viewed and downloaded on the provider website, **https://healthybluekansas.com/provider**.

For questions about the UM process, including requesting a free copy of our UM criteria, call Utilization Management at **833-838-2595.**

Utilization Management Decision-Making Affirmative Statements

As a corporation and as individuals involved in UM decisions, the health plan is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- The health plan does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.

- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Medical Policies, Clinical UM Guidelines, and Medical Drug Benefit Clinical Criteria

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. *Medical Policies*, *Clinical UM Guidelines*, and Medical Drug Benefit Clinical Criteria are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting prior authorization and claim decisions through the following websites:

- **Medical Policies & Clinical UM Guidelines**
- **Medical Drug Benefit Clinical Criteria: General Clinical Prior Authorization | KDHE, KS**

In addition, the following criteria/guidelines may be used:

- MCG Care Guidelines are also used when no specific medical policies exist.
- Behavioral Health utilizes the American Society for Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse treatment authorizations, with the exception of detoxification which uses MCG.

Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, and Centers for Medicare & Medicaid (CMS) requirements are used when determining eligibility for coverage and supersede any other UM criteria.

Prior Authorization Process

Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Look Up Tool, which can be found on Availity Essentials through Payer Spaces or the health plan provider website through the following link:

- **Precertification Lookup Tool**

A completed prior authorization request is required to eliminate delays in processing, which includes all required documentation, current clinical information, and a signed authorization form by the requesting provider. Documentation and forms required for prior authorization requests are located on our provider website.

Prior authorization requests or notifications can be submitted digitally through Availity Essentials at **Availity.com** and is the preferred method.

Additional information regarding the process to submit prior authorization requests is located in the ***Quick Reference Contact Information*** section of this manual.

Information Needed for a Hospitalized Member
For services or equipment that will be necessary for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the ***Discharge Planning*** section of this manual.

Determination Timelines

Utilization review timeliness standards are as follows:

Type of Request	Decision and Electronic/Written Notification Timeframes
Pre-service (Prospective)	
Urgent (expedited)	As expeditiously as the member's health condition requires, but no later than 72 hours (three calendar days) after receipt of request.
Non-urgent	Within seven calendar days following receipt of request.
Concurrent	
Urgent	As expeditiously as the member's health condition requires, but no later than 72 hours (three calendar days) after receipt of request.
Post-Service/Retrospective	
N/A	Within 30 calendar days from receipt of request.

For timeline exceptions, please refer to the provider website for prior authorization requirements.

Prior Authorization Not Required
If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations, and patient eligibility at the time services are rendered.

Incomplete Documentation
If the prior authorization documentation is incomplete or inadequate, the reviewer is unable to process the request. In such instances, the health plan will notify the provider and member to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the medical director will make a determination based on the information previously received.

Expedited/Urgent Care/STAT Request
Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in any of the following circumstances:

1. Serious jeopardy to the life, health, or safety of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
2. Serious jeopardy to the life, health, or safety of the member or others, due to the member's psychological state.
3. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
4. In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus.
5. In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; the practitioner must be allowed to act as the authorized representative of that member.

If we receive requests marked urgent and determine as a result of consultation with the provider that the request should be handled as non-urgent, we will process as non-urgent and document the consultation in the Medical Management System (MMS).

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary to ensure a seamless transition from the inpatient setting to outpatient services to improve health outcomes for our members. Our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's provider(s) regarding follow-up care after discharge and the provider is responsible for contacting the member to schedule all necessary follow-up care.

When additional or ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

For prior authorization requests for a member who is hospitalized at the time of the request, please clearly document at the top of the request to indicate that the member is hospitalized and has discharge planning needs. To eliminate delays in processing, please ensure all required documentation is submitted with the request along with any required signatures to the applicable department.

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include but are not limited to transportation, home health, durable medical equipment (DME), pharmacy, follow-up visits to practitioners, and outpatient procedures.

7. PROVIDER TYPES, ACCESS AND AVAILABILITY

Primary Care Provider Responsibilities

Providers are responsible for the complete care of Healthy Blue members, including:

- Providing primary care.
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions.
- Coordinating and monitoring referrals to specialist care.
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements.
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as they are available.
- Authorizing hospital services.
- Maintaining continuity of care.
- Assuring all medically necessary services are made available in a timely manner.
- Providing services ethically and legally and in a culturally competent manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment.
- Maintaining a medical record of all services including SDOH services, rendered by you and other referral providers.
- Communicating with members about treatment options available to them, including medication treatment option and social and community resources, regardless of benefit coverage limitations.
- Providing a minimum of 32 office hours per week of appointment availability as a PCP.
- Providing hours of operation for members that are no less than the hours of operation offered to any other patient.
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician.
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs).
- Continuing care in progress during and after termination of your contract for up to 60 days, until a continuity of care plan is in place to transition the member to another provider, or through postpartum care for pregnant members, in accordance with applicable state laws and regulations.

In addition to the above applicable Healthy Blue provider responsibilities, long-term services and supports (LTSS) home- and community-based services (HCBS) providers are subject to additional responsibilities based on state and federal requirements. HCBS Waivers are Medicaid programs designed to provide services to a person in their community instead of an institution, such as a nursing facility or State hospital. Detailed information about the HCBS Waiver in Kansas can be found at **https://kdads.ks.gov/kdads-commissions/long-term-services-supports/home-community-based-services-(hcbs)-programs**. All HCBS are to be delivered in compliance with the current, approved Waiver or other CMS-approved requirements and applicable state policies, including:

- Electronic Visit Verification (EVV) — required for HCBS, Personal Care Services (PCS), and Home Health Care Service (HHCS) claim submissions. Refer to Appendix F for services requiring (EVV).

- Home and Community Based Settings Rule (42 CFR § 441.301(c)(4)) — participating providers subject to the HCBS Settings Rule must maintain compliance with the Rule
- 1915(c) HCBS Waiver Provider qualifications, found here**: www.kmap-state-ks.us/Documents/Content/Checklists/HCBS.PDF**
- Coordination of care for members with substance use disorder services programs in support of member recovery.

You also have the responsibility to:

- **Communicate with Members:**
  - Make provisions to communicate in the language and appropriate literacy level used by the member. Contact Member Services or Provider Services for help with oral translation services if needed.
  - Promote health equity through empowering members with tools and resources specific to their whole health needs.
  - Freely communicate with members about their treatment, regardless of benefit coverage limitations.
  - Provide complete information concerning their diagnoses, evaluations, treatments, and prognoses, and give members the opportunity to participate in decisions involving their healthcare.
  - Advise members about their health status, medical care, social health resources, behavioral health resources, and treatment options, regardless of whether benefits for such care are provided under the program.
  - Advise members on treatments that may be self-administered.
  - Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- **Maintain Medical Records:**
  - Provide members with appropriate privacy.
  - Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
  - Maintain the confidentiality of family-planning information and records for each individual member, including those of members who are minors.
  - Comply with all applicable federal and state laws regarding the confidentiality of member records.
  - Agree that any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly delineated with entries regarding the provision of nonresearch-related care.
  - Share records subject to applicable confidentiality and *HIPAA* requirements.
  - Obtain/store medical records from any specialty referrals in members' medical records.
  - Manage the medical and healthcare needs of members to assure all medically necessary services are made available in a timely manner, as required by KanCare 3.0.
- **Cooperate and Communicate with Healthy Blue:**
  - To:
    - Internal and external quality assurance.
    - Utilization review.
    - Continuing education.
    - Complaint and grievance procedures when notified of a member grievance.

  - Inform Healthy Blue if a member objects to provision of any counseling, treatments, or referral services due to religious reasons.
  - Identify members with special health needs such employment, housing, or other social services during the course of any contact or member-initiated healthcare visit and report these members to a Healthy Blue representative so they can help them with additional services.
  - Identify members who would benefit from Healthy Blue's case management/disease management programs.
  - Comply with Healthy Blue's Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- **Cooperate and Communicate with Other Providers:**
  - Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
  - Coordinate the referral of patients to specialists and services that may be available through Medicaid.
  - Provide Case Management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's program.
  - Coordinate the services Healthy Blue furnishes to the member with the services the member receives from any other managed care organization (MCO) during member transition.
  - Share with other healthcare providers serving the member the results of your identification and assessment of any member with special healthcare needs (as defined by the state) so those activities are not duplicated.
- **Cooperate and Communicate with Other Agencies:**
  - Maintain communication with the appropriate agencies such as:
    - Local police.
    - Social services agencies.
    - Poison control centers.
    - Women, Infants and Children (WIC) program.
    - Community-Based Organizations that provide social supports
    - Local women's shelters
  - Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
  - Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
  - Coordinate the services Healthy Blue furnishes to the member with the services the member receives from any other MCO during ongoing care and transitions of care.

Who Can Be a Primary Care Provider?

Healthy Blue encourages the following types of practitioners to enroll within the KMAP Provider Portal and Enrollment Wizard as primary care providers (PCPs):

- General practitioner
- Family physician
- Pediatricians (serving members aged 0 to 20)
- Indian Health Services providers
- Obstetrics and gynecology (OB/GYN)
- Behavioral health providers
- Ancillary services
- Other specialists who meet all state requirements for providing primary care

As a PCP, you may practice in a(n):

- Solo or group setting.
- Clinic (for example, an FQHC or RHC).
- Outpatient clinic.
- Nursing facility.
- Indian health/Tribal 638 facility.

Primary Care Provider Onsite Availability

Providers are required to abide by the following standards to ensure access to care for Healthy Blue members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow Healthy Blue's referral/precertification guidelines. This is a requirement for covering physicians.

Healthy Blue encourages providers to offer after-hours office care in the evenings and on Saturdays. It is <u>not</u> acceptable to automatically direct the member to the emergency room when the PCP is not available.

Primary Care Provider Access and Availability

The ability for Healthy Blue to provide quality access to care depends upon provider's accessibility.* Providers are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours
Routine or preventive care	Within three weeks

* In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait-time is anticipated to be more than 45 minutes, the patient should be offered a new appointment.

As part of Healthy Blue's commitment to providing the best quality provider networks for its members, Healthy Blue conducts annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining appointment days.
- Denying, or not providing to a member, any covered service or availability of a facility.
- Conditioning the provision of care or otherwise discriminating against our members based on whether the members have executed advance directives.
- Providing a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at-large.

Healthy Blue will routinely monitor providers' adherence to access-to-care standards and appointment wait times. Providers are expected to meet federal and state accessibility standards, as well as those standards defined in the *Americans with Disabilities Act* of 1990. Healthcare services provided through Healthy Blue must be accessible to all members.

For urgent care and additional after-hours care information, see the ***Urgent Care/After-Hours Care*** section of this manual.

Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

To assist PCPs in meeting the needs of children with a mental health diagnosis, Healthy Blue provides access to consultations with child psychiatrists and other qualified behavioral health professionals. For more information on how to arrange for these consultations, call our Behavioral Health Care Coordinators at **833-838-2595**.

Access to Women's Health Specialists

Female members may directly access women's health specialists within Healthy Blue's network for covered routine and preventive healthcare services including maternity care, reproductive health services, gynecological care, and general examination as medically appropriate, including medically appropriate follow-up visits for these services.

Newly diagnosed pregnant women must be seen within their first trimester or within 10 calendar days from notification. Postpartum exams should be given between seven and 84 days after deliveries, regardless of the needs for Caesarean section postoperative visits.

Role and Responsibilities of Specialty Care Providers

Provider specialists will treat members who are referred by network PCPs or self-referred. Specialists are responsible for:

- Providing equitable and culturally competent care and treatment plans for all members referred to specialists.
- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to specialists.
- Rendering covered services only to the extent and duration indicated on the referral.
- Submitting required claims information, including the source of the referral and referral number.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and precertification of services at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis.
- Notifying the member's PCP when scheduling a hospital admission or any procedure requiring the PCP's approval.
- Coordinating care with other providers for:
  - Physical and behavioral health comorbidities.
  - Co-occurring behavioral health disorders.
- Adhering to the same responsibilities as the PCP.

Specialty Care Providers' Access and Availability

The ability for Healthy Blue to provide quality access to care depends upon your accessibility.* You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours of referral
Nonurgent sick care	Within 10 calendar days
Routine lab, X-ray (radiology) and optometry	Within three weeks
Mental health (MH)	1. Emergency/life threatening: immediately 2. Urgent/non-emergency: assessed within 72 hours of request for services 3. Routine/non-urgent: assessed within 10 business days of the request for services
Substance use disorder (SUD) services	1. Emergency/life-threatening: immediately 2. Urgent/non-emergency: assessed within 24 hours of request; services provided within 24 hours of assessment. 3. Routine/non-urgent: assessed within 10 business days of the request for services

Type of Care	Standard
	4. Pregnant women who are intravenous drug users and all other pregnant substance users must receive treatment within 24 hours of assessment. When it is not possible to admit the member within this timeframe, interim services must be made available within 48 hours of initial contract to include prenatal care. 5. Members who inject drugs must receive an assessment and must be admitted to treatment no later than 10 business days after making the request for assessment. If no program has the capacity to admit the member within the required timeframe, interim services must be made available to the member no later than 48 hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment.
All other specialty care	Within 30 calendar days

* In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Each member should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is expected to be over 45 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

As part of Healthy Blue's commitment to providing the best-quality provider service for its members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining appointment days.
- Denying or not providing to a member any covered service or availability of a facility (except in cases where Indian health service/Tribal 638 providers are prohibited from providing certain services due to cultural beliefs).
- Conditioning the provision of care or otherwise discriminating against our members based on whether the members have executed advance directives.
- Providing a member with any covered service that is different from, administered in a different manner than or at a different time than that given to other members, other public or private patients, or the public at large.

Healthy Blue will routinely monitor providers' adherence to access-to-care standards and appointment wait times. Providers are expected to meet federal and state accessibility standards and those standards defined in

the *Americans with Disabilities Act* of 1990. Healthcare services provided through Healthy Blue must be accessible to all members.

Urgent Care/After-hours Care

Healthy Blue encourages its members to contact their PCPs if they need urgent care. If providers are unable to see the member, providers can refer them to one of Healthy Blue's participating urgent care centers or another provider who offers after-hours care. Prior authorization is not required.

Prior authorization is required if a Healthy Blue provider refers a member to an out-of-network provider.

Healthy Blue strongly encourages PCPs to provide evening and Saturday appointment access. To learn more about participating in the after-hours care program, call your local Provider Relations representative.

Emergency Services

Emergency services require no prior authorization. Healthy Blue does not deny access to or discourage its members from using 911 or accessing emergency services when warranted.

When a member seeks emergency services at a hospital, they are examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

If there is a concern about transferring the member, Healthy Blue defers to the judgment of the attending physician. If the emergency department cannot stabilize and release a member, Healthy Blue will help coordinate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

Emergency Room Prudent Layperson Review

Reviews of emergency room (ER) claims include comparisons of the admission and discharge diagnosis codes on each claim against a KDHE-approved list for outpatient hospital claims. If the admission or discharge (principal) diagnosis codes match a diagnosis code on the list, the claim will process for reimbursement per the hospital's contract. If the admission or discharge diagnosis codes do not match a diagnosis code on the list, the claim will process for reimbursement at the current outpatient rate. An *EOP* will indicate the rate, including an explanation code, with the option to dispute within 90 calendar days by completing a *Provider Payment Dispute and Correspondence Submission* form and submitting the medical records. Medical records should not be submitted with the initial claim.

Any hospital claim dispute of outpatient-level reimbursements must be submitted in writing and filed within 90 calendar days of the date on the *EOP* in order to be considered. Each claim dispute should include the Healthy Blue *Provider Payment Dispute and Correspondence Submission* form as the cover page with "ER Hospital Claim Dispute" typed or written clearly.

All written correspondence must clearly indicate a provider is requesting a claims dispute of an ER outpatient payment. The ER medical records and written rationale supporting the claims dispute should be mailed to Healthy Blue.

Indian Health Services, Urban Indian Health Clinics, and Tribal Health Centers

To promote culturally sensitive, equitable, and convenient healthcare, Healthy Blue members are permitted to seek care from any Indian Health Services (IHS) or tribal-care provider defined in the *Indian Health Care Improvement Act*, 25 U.S.C. §§1601, et seq., regardless of whether the provider participates in the Healthy Blue provider network. Out-of-network IHS providers must coordinate with Healthy Blue with respect to payments and ensure any cost to members is not greater than it would be if services were furnished within the network.

Individuals enrolled in a federally recognized Indian Nation may access IHS, Urban Indian Health Clinics, or Tribal 638 and may see providers at will and without referral. Healthy Blue does not prevent members who are IHS beneficiaries from seeking care from IHS and tribal providers or from network providers due to their status as Native Americans.

Precertification is not required for services provided within the IHS, Urban Indian Health Clinics, or Tribal 638 network.

To meet licensure requirements for network participation, Healthy Blue accepts a current license to practice in the United States or its territories from any individual provider employed by the IHS, Urban Indian Health Clinic, or Tribal 638 facility. Any provider of substance use disorder (SUD) treatment services must be licensed by the state to provide SUD treatment services in that state’s facility setting.

8. HEALTHY BLUE LONG-TERM SERVICES AND SUPPORTS (LTSS) AND HOME AND COMMUNITY BASED SERVICES (HCBS)

Healthy Blue LTSS/HCBS is a statewide coordinated care program for Kansas' Medicaid enrollees to provide Long-Term Services and Supports (LTSS) and Home- and Community-Based Services (HCBS) to those who are receiving services in a nursing facility or in the community. Healthy Blue's fundamental approach through the LTSS/HCBS program is founded on person-centered principles and practices to facilitate member- and family-driven services and supports that are responsive and meaningful to evolving preferences, support needs and personal goals.

Healthy Blue is dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals. Through this commitment, Healthy Blue supports members to succeed in communities of their choice, and also partners with providers, stakeholders, and associations.

The primary quality goals of this program are to:

- Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses social determinants of health (SDOH).
- Ensure continuity of care and seamless experiences for members as they transition into the Healthy Blue LTSS/HCBS program, among providers, settings, or coverage types.
- Assure timely access to appropriate services and supports to enable members to live in their settings of choice and promote their well-being and quality of life.

LTSS/HCBS providers will be assigned a local and dedicated provider relations consultant who will work hand-in-hand to provide in-person and virtual education and training. This includes monthly webinars, office hours, and onboarding orientations to support providers with credentialing/contracting and claims and develop collaborative provider relationships.

The LTSS/HCBS provider relations consultants will collaborate with the Workforce Development Administrator and Provider Capacity Specialists, who will work with providers to assess their workforce barriers and identify financial incentives, training, and tools needed for providers to increase their capacity (through recruitment, retention, and training).

Initial HCBS Credentialing Review Process

Healthy Blue will review home- and community-based services (HCBS) providers in a manner that is consistent with applicable 1915(c) HCBS Waiver provider qualification requirements and certification standards identified by the State for HCBS providers and verify compliance with the HCBS settings rule (42 CFR 441.301(c)(4)), as well as any MCO specific credentialing requirements.

Upon application and credentialing documents being received, Healthy Blue will review the documents submitted to verify certification and enrollment are accurate and in accordance with the provider's qualifications. After initial application for network participation, the review of HCBS providers will include the collection of required documents from the state that includes but is not limited to:

- A copy of the current Certificate of Insurance (COI)
- A copy of the current W-9 form
- A copy of the accreditation letter (if applicable)
- Additional documents as required

In addition to the required documentation, Healthy Blue's LTSS/HCBS Provider Qualifications include that a provider:

- Is not excluded from participation in the LTSS program by the Federal Government under Section 1128 or Section 1128A of the *Social Security Act* or by the State's Medicaid program for fraud, abuse, or neglect.
- Is not an individual or entity who is debarred, suspended, or otherwise excluded from participating in accordance with 42 CFR 438.610 as defined in the Federal Acquisition Regulation, of a person described above.
- Has a National Provider Identifier (NPI) number (non-HCBS providers only) or has an Atypical Provider Identifier (API) (if applicable).
- Is compliant with the HCBS Settings Rule detailed in *42 CFR § 441.301(c)(4)-(5).*
- Maintains records of services provided for 10 years in accordance with K.A.R 100-24/K.A.R 28-34.
- Maintains records of services provided.
- Is compliant with accessibility standards issued under the *Americans with Disabilities Act* (*ADA*) where applicable.
- Has policies and processes in place to ensure:
  - Appropriate use of the EVV system.
  - Cultural and linguistic competency and training.

Re-Credentialing

Ongoing program participation eligibility for HCBS providers is verified on a three-year cycle. As part of ongoing recertification requirements, Healthy Blue will review HCBS provider data, including but not limited to HCBS utilization management, HCBS provider satisfaction scores, and HCBS Settings Rule reviews to assess the provider's continued participation in the network. Additionally, LTSS/HCBS Provider Relations Consultants shall conduct Support Visits to ensure providers remain in compliance with contractual requirements and the provider's eligibility to participate in the program. The assigned provider relations consultants will utilize an LTSS Provider Relations Site Visit Tool to document and track continued program eligibility. At a minimum, the process shall include verification of continued licensure (only as applicable) and/or certification and compliance with policies and procedures.

LTSS/HCBS-Specific Value Based Payment

Healthy Blue provides a proposed list of Value Based Payment (VBP) Arrangements for LTSS/HCBS providers. The Value Based Payments are incentives offered to enrolled providers who meet the outlined performance metrics throughout the program. As new programs are designed an approved by the state, they will be communicated in future manuals. For the latest updates related to Healthy Blue programs, refer to the Healthy Blue provider website at **https://www.healthybluekansas.com/provider**.

Proposed LTSS-Specific programs	Description and methodology
Personal Attendant Care Quality Incentive Program (PACQIP)	Incentives offered for Attendant Care (AC) agencies who meet quality, service, utilization, and workforce development goals. Performance indicators include inpatient utilization, emergency room (ER) utilization, AC caregiver training, AC caregiver assignment consistency, and member satisfaction with AC provider services.
Nursing Facility Quality Incentive Program (NFQIP)	High-performing NFs that meet quality, service, utilization, and workforce development goals are eligible to receive incentive payments. Performance indicators used include inpatient utilization, ER utilization, inpatient admissions within 30 days of NF discharge, patient satisfaction, and CMS Nursing Home Compare Star Ratings for Quality Measures, and Staffing.

Healthy Blue will evaluate opportunities to include a health equity enhancement to our provider incentive programs. We will leverage experience from the KanCare program health equity enhancement that complements our existing Quality Incentive Program and includes bonus payments to providers who demonstrate improvements in delivering the preventive services needed to reverse racial health disparities. We are collecting baseline data for health equity incentives with the goal of making future bonus payments available. Based on this analysis, we will determine appropriate performance metrics for this incentive, such as improving a minority-specific rate for a HEDIS® measure from the baseline period to the performance measurement period. As we pilot this enhancement, we will assess opportunities to tailor it for our LTSS provider incentive programs.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Nursing Facility Eligibility

Nursing Facility Level of Care (NFLOC) is determined based on state law and administrative rule. The population for this program is individuals 65 and older who are functionally eligible for Medicaid, on the basis of age, blindness, or disability and have limited income and resources. (Frail Elderly or FE Waiver)

Nursing Facility — Pre-Admission Screening and Resident Review

Healthy Blue follows state policy found in the Client Assessment, Referral and Evaluation (CARE) program for Level of Care (LOC) Level I and Level II and Pre-Admission Screening Resident Review (PASRR) requirements. Level of Care and PASRR determinations are conducted by assessors through the local Area Agencies on Aging (AAA). Additional information on the CARE Program can be found here: **Client Assessment, Referral and Evaluation (CARE) (ks.gov)**.

Before the nursing facility can be reimbursed for the care provided, the nursing facility or other appropriate entity must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State or Assessor must then approve the PASRR request and designate the appropriate level of care in the

State's system. Healthy Blue coordinates care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR.

Healthy Blue Referral Process Providers are selected during the member assessment process completed by Healthy Blue. Petitioning members with the expectation of being selected as the service provider or petitioning existing members who receive Healthy Blue services to change their providers is prohibited. Additionally, communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential Healthy Blue members is prohibited. Requests from a provider to be added as a service provider for any member will prompt the assigned Healthy Blue coordinator to outreach to the member for clarification of the member preference. Updates to add service providers are solely driven by members and their designated representatives.

Person-Centered Practices

All providers are expected to conduct all member interactions using a person-centered approach and ensure member choice and self-determination are supported at all times. For successful person-centered planning to occur, the provider must have a clear understanding and shared appreciation of what is important to and for each member and how they want to be supported.

Using person-centered language is an important aspect of person-centered practices as it recognizes the impact of language on thoughts and actions. It ensures language does not diminish the uniqueness and intrinsic value of each individual and allows a full range of thoughts, feelings, and experiences to be communicated. It is important to emphasize cultural preferences and communication style when training a direct support professional, so they can best support the individual.

The HCBS Settings Rule supports enhanced quality in HCBS programs that is central to an effective and meaningful person-centered planning process. A rights-based, person-centered planning process is a means to ensure LTSS consumers receive effective and robust person-centered care that:

- Is integrated in and supports full access of individuals to the greater community.
- Is selected by the individual from among setting options based on the individual's needs, preferences, and for residential settings, resources available for room and board.
- Optimizes individual initiative, autonomy, and independence making life choices.
- Facilitates individual choice regarding services and supports and who provides them.
- Supports a life of purpose and meaning.

Healthy Blue Care Coordination

Each member in the Healthy Blue Care Coordination program will have an assigned Care Coordinator who will facilitate the coordination of physical and behavioral services and supports that are documented and tracked in an Individualized Plan of Service or Person-Centered Service Plan (PCSP). Members who are eligible for HCBS waivers will have an assigned care coordinator to facilitate the coordination of LTSS and HCBS services which are captured in a PCSP. The care coordinators are the central, primary point of contacts to ensure consistent ongoing communication between the member, providers, caretakers, and all other participants of the Interdisciplinary team (IDT) The care coordinator's primary role includes:

- Supporting members with timely and coordinated access to an array of providers, covered services, and supports.
- Monitoring for SDOH support needs and connecting individuals to community-based services.
- Using a person-centered approach at all times to ensure each member remains in control of their care planning and their individual needs are supported in a way that aligns with how they want to be supported.
- Representation and advocacy with agencies, providers, and facilities on behalf of the member.
- Working with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

Care coordinators play an important role in relation to LTSS/HCBS providers. Some of the primary ways a care or service coordinator support providers includes:

- Assessing for and communicating information about member-specific support needs and preferences to facilitate effective referral matches.
- Facilitating provider selection by providing the member with all available options to support service delivery.
- Connecting the member to community-based resources to address all identified SDOH needs.
- Submitting timely service authorization requests that align with Care and Service Plans.
- Engaging with all LTSS/HCBS providers and community-based providers identified to ensure they fully understand their role in supporting the member to achieve their desired outcomes as identified in the Service Plan or Person-Centered Service Plan.
- Following up with the member to ensure all service delivery is in place and is being conducted in alignment with the Service Plan or Person-Centered Service Plan to include both LTSS providers and community-based supports.
- Engaging with providers in the development and ongoing revisions of Care and Service Plans.
- Keeping providers informed about the status of Care and Service Plan outcomes and changes.
- Facilitating resolution when a member/provider grievance occurs.

It is the responsibility of every provider to notify the care coordinator if any of these scenarios are identified by the provider:

- Change in member condition, environment, or availability of caregiver supports
- An inpatient hospitalization or ER occurrence
- Suspected abuse, neglect, or exploitation
- Needed modification to a goal or support strategy or barriers to achieve the member's desired outcome
- A change in the member's preferences about the existing Care or Service Plan
- Any other situation that would necessitate a Care or Service Plan revision

We will provide training to all LTSS/HCBS providers regarding the value and available modes of communication and remind them that the member's identification card indicates if a member is enrolled in Healthy Blue. Through the LTSS/HCBS provider training, providers will also be educated on how to contact the care and service coordinators, including contacting Member Services.

Individualized Care Plans and Service Plans

Healthy Blue uses Individualized Care Plans and Service Plans in accordance with the minimum requirements as defined by the State, compliant with NCQA and HCBS Settings Rule standards, and inclusive of the Healthy Blue Best Practice model. Healthy Blue care coordinators support each member with facilitating the process to develop a Plan of Service/Person Centered Service Plan (PS/PCSP) using a person-centered planning approach to document the member's strengths, support needs, goals, desired outcomes, and preferences of how each member wants to be supported through a combination of paid, community-based, and natural supports. The person-centered planning process is always directed by the member and may include representatives of the member's choosing to assist with decision-making and to participate in the care planning process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the member, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting PS/PCSPs, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. HCBS services will be authorized, provided, and reimbursed only as specified in the Person-Centered Service Plan.

For Members Residing in a Nursing Facility

For members in a nursing facility, the member's care coordinator may:

- Defer to the Service Plan developed by the nursing facility for service delivery in lieu of creating an additional Service Plan if the existing plan is sufficient to address all of the member's support needs.
- Supplement the Service Plan as necessary with the development and implementation of targeted strategies to improve health, functional ability, quality of life outcomes (for example, related to Condition Care services or pharmacy management), or to increase and/or maintain functional abilities.
- Facilitate resolution of any discrepancies between the NF plan of care and Healthy Blue Individualized Care Plan (ICP)/Service Plan (SP) by communicating directly with the NF, member, and other Interdisciplinary Care Team (ICT) members as appropriate ensuring all plans of care are updated to be aligned.
- Participate in care rounds.
- Have regular ongoing contact with the member and their assigned representatives where applicable to monitor the progress of the NF plan of care, ICP, and SP as well as identification of any new or escalated issues.
- Perform an ongoing assessment of the member's desire to transition to community and the supports needed to do so.
- Offer comprehensive transition support upon a member's decision to transition back to the community or to a less restrictive environment that includes identification and coordination of all formal and community-based supports needed to support a safe transition. Coordination with the transition IDT will include the NF and HCBS providers to ensure continuity of care throughout the transition process.

Care coordinators will participate in the nursing facility's care planning process and advocate for the member. All members will still receive a PS/PCSP with support from their care coordinator.
The member's care coordinator as well as the Transition Support team are responsible for coordinating the member's physical health, behavioral health, and LTSS needs. This will include coordinating with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by Healthy Blue that are beyond the scope of the nursing facility services benefit.

For Members in Community-Based Settings

For members in community-based settings, the care coordinator will coordinate and facilitate a care/service planning team that includes the member, those identified by the member who act as natural supports, providers, other support coordinators, and community-based partners. The care coordinator will include or seek input from others as authorized by the member to assist with needs assessment and care planning activities as needed.

Some of the activities the care coordinator conducts as a part of Plan of Service/Person-Centered Service Plan development include:

- Gathering pertinent demographic information regarding the member, including the name and contact information of any representative and a list of other persons authorized by the member to have access to healthcare (including long-term-care-related information) and assisting with assessment, planning and/or implementation of healthcare (including long term care related services and supports).
- Determining care, including specific tasks and functions that will be performed by family members and other caregivers.
- Determining home health, private duty nursing, and LTSS/HCBS services the member will receive from other payer sources including the payer of such services.
- Determining home health and private duty nursing services that will be authorized by Healthy Blue.

HCBS services that will be authorized by Healthy Blue care coordinators include:

- The amount, frequency, duration, codes, and scope (tasks and functions to be performed) of each service to be provided.
- The schedule of when such care is needed.

The Plan of Service/Person-Centered Service Plan will include the following elements:

- Member's name and demographics
- The Service Plan type
- Date, location, and who was involved in the planning meeting
- Date of last Level of Care Assessment
- Description of medical equipment used or needed by the member (if applicable)
- Description of each member's communication style as well as any special communication needs, including interpreters or special devices
- Description of goals, objectives, and desired health; and the functional and quality of life outcomes for the member

- Description of other services that will be provided to the member, including:
  - Covered physical and behavioral health services that will be provided by Healthy Blue to help the member maintain or improve their physical or behavioral health status, or functional abilities and maximize independence
  - Other social support services and assistance needed in order to ensure the member's health, safety and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement
  - Any noncovered services including services provided by other community resources, including plans to link the member to financial assistance programs, including housing, utilities and food as needed
- Relevant information from the person's treatment plan for any member receiving behavioral health services that is needed by a LTSS provider, caregiver, or the care coordinator to ensure appropriate delivery of services or coordination of services
- Review and acknowledgment of key member rights and informed choices
- Frequency of planned care coordinator contacts needed, which will include consideration of the person's member needs and circumstances
- Additional information for members who elect self-direction of HCBS, including whether the member requires a representative to participate in consumer direction and the specific services that will be self-directed
- Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol
- A disaster preparedness plan specific to the member
- All key signatures for accepting or declining of the PCSP.

The member's care coordinator will provide a copy of the member's completed Individualized Plan of Service/Person-Centered Service Plan including any updates, to the member, the member's representative, the member's providers authorized to deliver care to the member, and other IDT members as applicable. A member can elect not to share their Plan of Service/Person-Centered Service Plan When this occurs, the care coordinator will ensure that providers who do not receive a copy are informed in writing of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including the tasks and functions to be performed.

Shortly after completing a reassessment of a member's needs, the member's care coordinator/care coordination team will update the member's plan of care as appropriate and authorize and initiate HCBS in the updated Service Plan.

Member Enrollment

For individuals who come into the program with no current Medicaid coverage, MCO assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three months retroactively from their application date.

Individuals transitioning from an existing Medicaid Managed Care program or FFS, MCO assignment will be effective the first day of the month following the notice of change in eligibility.

Plan selection can be made by calling the State's Managed Care Enrollment Center within 60 days of coverage start. The State's Managed Care Enrollment Center will be responsible for providing choice counseling to the member. If a member does not select a plan there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).

In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); and 42 CFR 438.56(c)(2)(i)-(iii), members have the right to disenroll from the Contractor:

- For just cause at any time.
- Without cause within 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.
- Without cause at least once every 12 months.
- Without cause when Healthy Blue repeatedly fails to meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 CFR 438.56(b)-(d).
- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.
- During a plan selection period which will be aligned with the Medicare open enrollment window to be effective the following calendar year.

Home and Community Based Service Descriptions

Members eligible for home- and community-based services (HCBS) may use different services to meet their support needs, in combination with informal caregiver supports and other community resources. Through the development of the Person-Centered Service Plan (PCSP), members and their care and service coordinators along with input from others chosen by the member will determine the best supports to meet the person's needs and support achievement of self-identified quality of life goals.

Home and Community-Based Services Settings Rule Compliance

HCBS:

- Is integrated in and supports access to the greater community.
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.
- Ensures the person receives services in the community to the same degree of access as individuals not receiving Medicaid home- and community-based services.
- Is selected by the person among setting options including non-disability-specific settings and an option for a private unit in a residential setting.

The intent of the HCBS final rule is to ensure members receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities have full access to benefits of community living and an opportunity to receive services in the most integrated setting appropriate and enhance the quality of HCBS and provide protections to participants.

HCBS Final Settings Rule Compliance is assessed by the Kansas Department of Aging and Disability Services via the HCBS Compliance Portal. All settings supporting HCBS participants must demonstrate compliance with 42 C.F.R. § 441.301(c) to be determined compliant and receive a current HCBS Compliance Certificate. Healthy Blue will verify compliance with the HCBS Settings Rule as a part of the HCBS provider qualification audit. Acceptable documentation includes:

1. A current HCBS Compliance Certificate, or
2. A signed Heightened Scrutiny Attestation

Additionally, Healthy Blue provider relations representatives will complete annual provider visits that include evaluating physical location, policies, procedures, and other written documentation, employee training, and sampling employee files. In addition, we will conduct ongoing provider education training and technical assistance on the HCBS Settings Rule as deemed necessary.

The Healthy Blue Settings Compliance Committee will review referrals provided from the care/service coordinator leadership and as part of their review will complete the following:

- Review any proposed or emergency right restrictions and restraints included and not included in a Behavioral Support Plan (BSP), PCSP or POC for potential human rights violations and ensuring informed consent of any restriction.
- Provide input for any modifications to member's rights when the member resides in a provider owned or controlled residential setting prior to modification being included in member's person-centered support plan.
- Review potential violations to HCBS Settings Rules in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for Healthy Blue members that may be in violation of HCBS Settings Rules and make recommendations for coming into compliance with HCBS Settings rules.
- Review and make recommendations regarding complaints received pertaining to potential human rights violations.
- Ensure proposed restriction is the least restrictive viable alternative and is not excessive.
- Ensure proposed restriction is not for staff convenience.

Electronic Visit Verification System

The *21st Century Cures Act* (*Cures Act*), signed into law on December 13, 2016, requires states to implement an Electronic Visit Verification (EVV) system for Personal Care Services and Home Health Care Services. All services that require EVV must be submitted via Authenticare (or through an approved third-party EVV vendor that sends visit data to Authenticare).

Electronic Visit Verification PCS and HHCS visit codes can be found at **https://www.kancare.ks.gov/home/showpublisheddocument/1146/638576002343130000**.

Information about the state's AuthentiCare system can be found at **kancare.ks.gov/providers/training-resources/electronic-visit-verification**. Healthy Blue will use the Kansas AuthentiCare system to accept claims from Home and Community Based (HCBS) Providers. If you are not currently registered with AuthentiCare, please do so at **www.authenticare.com/kansas/register.aspx**.

Providers are responsible for ensuring their chosen EVV system is approved by the State of Kansas and complies with federal requirements for documentation of the following visit information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

The State of Kansas also requires:

- Caregiver observations
- Place of Service codes

The primary methods of capturing visit records are:

- Authenticare application (smartphone application)
- Telephonic Visit Verification (using a member's landline telephone)

Healthy Blue encourages the use of mobile or telephonic visit verification to capture visit information. In the event neither method is available manual visit entry is available to document visit information. Healthy Blue will monitor visit information for excessive use of manual visit entry method and proactively support providers to reduce the number of visits that are manual entry as a percentage of total visits recorded.

Contracted providers must have at least two staff persons fully trained on the EVV system that can train others on using the device in the member's home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring activity and supporting the proper use of visit verification, including monitoring use of manual visit entry.

Performance Metrics for Provider Compliance

Healthy Blue monitors the following criteria to determine provider agency compliance:

- Manual visit entry percentage as a percentage of total visits recorded
- Visits are conducted at an acceptable location
- Caregiver qualifications align to the services delivered
- Caregiver activities and completions are appropriate for the service delivered

Claims Submission

For detailed information related to HCBS Program Billing, including services, HCPCS and benefit limits, please see Appendix F.

State of Kansas EVV Application should be used for the review and submittal of original claims for EVV Covered HCBS-PCS and Home Health Care Services (HHCS). Beginning January 22, 2025, this is the only approved method for original claims submittals for EVV Covered HCBS-PCS and Home Health Care Services (HHCS).

Healthy Blue providers will use Care Central as the primary method for submitting electronic claims for non-EVV covered services (note: EVV required procedure codes must be submitted via Authenticare). Accessible through Availity Essential's Payer Spaces, Care Central is a one-stop shop for HCBS/Atypical providers, with tailored billing, authorization, and member management dashboards in addition to other provider supporting features, which:

- Enables a simplified, seamless, and tailored online experience reducing administrative burden.
- Reduces errors, manual processes, and obsolete technology.
- Empowers the provider with quick access to information necessary to initiate and maintain member care.
- Streamlines resources and contacts optimized for LTSS/Atypical providers.
- Provides clear line of site into critical data and reporting.

Claims submission within Care Central leverages the information we already have about an HCBS/Atypical provider obtained through the Availity registration process to streamline claim(s) submission. When submitting a claim, the provider will be required to first select the member(s) who has an existing authorization on the member dashboard and will then be requested to enter claims information. Claims information, if for the same service, can be entered once to submit claims for multiple members. Claims settings, once established for a provider, can be edited but will not be required to be entered each time a claim needs to be submitted. Once a claim has been reviewed and submitted, providers can track the status of their claim in the Claims Dashboard tab within Care Central.

Healthy Blue will finalize a clean electronic HCBS claim after the claim is received. Clean claims, those which can be processed without requiring additional information, are paid within 30 calendar days. H

Payment of Claims

Once we receive a claim, Healthy Blue takes the following steps:

- Healthy Blue's processing systems analyze and validate the claim for member eligibility, covered services, and proper formatting.
- Healthy Blue's processing systems validate billing, rendering, and referring provider information against Healthy Blue and KanCare files.
- Healthy Blue's processing systems validate against processing rules such as a requirement for referral, prior authorization, or NDC and McKesson ClaimsXten Correct Coding rules.
- Medical review is performed, as necessary.
- If no payment is warranted, Healthy Blue sends a claims remittance advice to the provider with the specific claims processing information.
- Healthy Blue systems reference Groupers, Pricers, and Fee Schedules based on the type of claim to determine the pricing.

Monitoring Submitted Claims

Submitted claims can be monitored within Availity Essentials by navigating to Claim & Payments > Claim Status. Additionally, LTSS/HCBS providers can further view the status of their claims by navigating to the Care Central

application with Payer Spaces. Monitoring claims within Care Central can be completed in the Claims tab. It is here where providers have the ability to see the status of their claims along with other cumulative information about their claim history.

Critical Incident Reporting and Management

We have a critical incident reporting and management system for incidents that occur in a home- and community-based long-term care services and supports delivery setting.

We will identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. We will regularly:

- Review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types).
- Review the findings from investigations (including findings from Adult Protective Services and Child Protective Services if available).
- Identify trends and patterns.
- Identify opportunities for improvement.
- Develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS.

Critical incidents include the following incidents when they occur in a waiver setting:

- Unexpected death
- Suspected physical or mental abuse
- Theft or financial exploitation
- Severe injury sustained
- Medication error
- Sexual abuse and/or suspected sexual abuse
- Abuse and neglect and/or suspected abuse and neglect

Providers must report critical incidents to Healthy Blue in accordance with applicable requirements. The maximum time frame for reporting an incident to Healthy Blue is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person/agency/entity making the initial report will submit a follow-up written report within 48 hours. A report must also be filed with KDADS through their Adverse Incident Reporting (AIR) system. Instructions can be found at **www.kdads.ks.gov/provider-home/providers/adverse-incident-reporting**.

Suspected abuse, neglect, and exploitation of members who are adults must be immediately reported. Suspected brutality, abuse, or neglect of members who are children must also be immediately reported.

Providers must immediately (within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

Waiver providers with a critical incident conduct an internal critical incident investigation and must submit a report on the investigation. The time frame for submitting the report on the investigation:

- Must be as soon as possible.
- May be based on the severity of the incident.
- Will be no more than 30 days after the date of the incident except under extenuating circumstances.

Healthy Blue will review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Providers must cooperate with any investigation conducted by Healthy Blue or outside agencies (for example, KanCare, Adult Protective Services, Child Protective Services, and law enforcement).
We will:

- Review all of the fiscal employer agent's (FEA) reports regarding investigations of critical incidents and follow-up with the FEA as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.
- Provide appropriate training and take corrective action as needed to ensure staff, contract HCBS providers, the FEA and workers comply with critical incident requirements.
- Conduct oversight, including oversight of staff, contract HCBS providers and the FEA to ensure the Healthy Blue policies and procedures are being followed and necessary follow-up is being conducted in a timely manner.

9. PROVIDER PROCEDURES, TOOLS, AND SUPPORT

Behavioral Health Consultations

Healthy Blue in Kansas will provide all contracted PCPs with opportunities to consult with behavioral health specialists by logging in to our provider self-service site at **https://healthybluekansas.com/provider**. For more information about this and other behavioral health consultation resources, visit our website or call our Behavioral Health Care Coordinators at **833-838-2595**.

Pregnant woman with behavioral health conditions often present with multiple, complex issues that could require specialist referrals and/or coordination of care. For assistance obtaining consultations from, or referrals to, behavioral health specialists to assist in care management for these members or to make referrals for care coordination services, call our Behavioral Health Coordinator team.

Behavioral Health Screening Tools

We also provide screening tools on our provider self-service site for common behavioral health disorders like depression, Alzheimer's disease, dementia, and substance use. If you have questions about these tools, call our Behavioral Health Coordinators.

Submitting Provider Demographic Data Requests

Please update your demographic information with Kansas Medical Assistance Program (KMAP). You can contact KMAP directly at **800-933-6593** or visit the KMAP Provider Portal at: **https://portal.kmap-state-ks.us/PublicPage/Public/ProviderHome/**.

Covering Physicians

During your absence or periods of unavailability, you must arrange for coverage for our members assigned to your panel. You will be responsible for making arrangements with the following to get care for our members:

- One or more network providers
- Other similarly licensed and qualified participating providers who have appropriate medical staff privileges at the same network hospitals or medical groups

The covering providers must agree to the terms and conditions of our network provider agreement, including applicable limitations on compensation, billing and participation.

You are solely responsible for:

- A non-network provider's adherence to our network provider agreement.
- Any fees or monies due and owed to any non-network provider who offers substitute coverage to our members on the provider's behalf.

Cultural and Linguistically Appropriate Services

Kansas patient populations continue to become more diverse, requiring equitable and culturally specific solutions to maintain high quality of care. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Healthy Blue is committed to working together to achieve health equity.

Health equity can be defined as the idea that everyone has a fair and just opportunity to be as healthy as possible, regardless of their circumstances. For health equity to exist, we must eliminate obstacles to health. Some of these obstacles arise because of discrimination based on race, age, disability, gender identity, sexual orientation, where someone lives or socioeconomic status. This is why Healthy Blue is dedicated to advancing health equity.

For providers, one aspect of our health equity program is to sustain a culture of health equity through culturally competent and accessibility of healthcare services. The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.
Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including but not limited to the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met.
- Formulate culturally competent treatment plans. Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the *Americans with Disabilities Act* (*ADA*).
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Healthy Blue encourages providers to access and use the following resources.

MyDiversePatients.com

The My Diverse Patient website offers resources, information, and techniques to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice- Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement)

A training resource to promote efforts to identify and lower health disparities and improve member experiences. Healthy Blue will work collaboratively with providers offering both in-person and webinar training opportunities to support provider's efforts to communicate, care and improve the health of the members they serve. Connect with your Provider Relationship Account Management representative or access training resources on our website at **https://healthybluekansas.com/provider.**

Caring for Diverse Populations Toolkit

A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Healthy Blue requires and provides training on cultural competence, including tribal awareness, to behavioral health network providers for a minimum of three hours per year and as directed by the needs assessments.

In addition, providers should attempt to collect member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, and religion. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Healthy Blue appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes. The toolkit is available on our website at **https://healthybluekansas.com/provider.**

Emergency Services

The health plan provides a 24-hour Nurse HelpLine with clinical staff to provide triage advice and referrals (if necessary) and to make treatment arrangements for the member. The service is available 24 hours a day, 7 days a week. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Healthy Blue encourages its members to contact their PCP in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer the member to one of our participating urgent care centers. If the member needs care during nonbusiness hours, the member can be seen by a provider who participates in our after-hours care program. Prior authorization is not required for a member to access a participating urgent care center or a provider participating in our after-hours care program.

Healthy Blue does **not** deny access to or discourage its members from using the 911 emergency system or accessing emergency services when warranted. Emergency services require no prior authorization. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in:

- Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

An emergency behavioral health condition is defined as any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing average knowledge of medicine and health:

- Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others.
- Renders the member incapable of controlling, knowing or understanding the consequences of their actions.

Emergency response is coordinated with community services, including the following (if applicable):

- Police, fire, and EMS departments
- Juvenile probation
- The judicial system
- Child protective services
- Chemical dependency agencies

- Emergency services
- Local mental health authorities

When a member seeks emergency services at a hospital, we request immediate notification by network hospitals of emergent admissions. Our Medical Management staff will verify eligibility and determine benefit coverage. The determination as to whether the need for those services exists will be made for purposes of treatment. The determination is made by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate the results of the emergency medical screening examination in the member's chart. We will compensate the provider for the screenings, evaluations, and examinations that are reasonable and calculated to assist the provider in determining whether or not the patient's condition is an emergency medical condition.
If there is concern surrounding the transfer of a patient (in other words, whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on the health plan. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Post-stabilization care services are covered services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition. Healthy Blue will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Fraud, Waste, and Abuse

First Line of Defense Against Fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse.

Our goal is to make sure our healthcare program works well and that we catch any problems like fraud, waste, or abuse. We start by learning about these issues and being aware of them:

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- **Abuse:** Behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet

professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

Every member identification card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Copayments for office visits, emergency room visits and pharmacy services (if applicable)
- Behavioral health benefit
- Vision service plan telephone number and dental service plan telephone number
- Member Services, 24-hour Nurse Help Line, and Behavioral Health Crisis Line telephone numbers

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries through Availity Essentials or by calling Provider Services at **833-838-2595**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOBs) for any errors and then contact member services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the ***Report Waste, Fraud and Abuse*** form.
- Calling our SIU fraud referral hotline: 866-847-8247
- Calling Provider Services: **833-838-2595**

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you

to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA)

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a **provider** (for example, a doctor, dentist, counselor, medical supply company) include:

- Name, address and phone number of provider
- Name and address of the facility (for example, hospital, nursing home, home health agency)
- Medicaid number of the provider and facility if you have it
- Type of provider (for example, doctor, dentist, therapist, pharmacist)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a **member** include:

- The member's name
- The member's date of birth, member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste, and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state,

regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment on future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment claim review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or claims activity that indicates the provider is an outlier compared to their peers.

Once a claim, or a provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the provider's action(s) may involve FWA, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of their prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to plan members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue, or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their *Provider Agreement*, proper billing procedures, and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse, the SIU:

- May present the provider to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will refer the provider to other authorities as applicable and/or designated by the State.
- Will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste, or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan, with state approval.

Offsets

Healthy Blue shall be entitled to offset claims and recoup an amount equal to any overpayments (“Overpayment Amount”) or improper payments made by the health plan to a provider or facility against any payments due and payable by Healthy Blue to the provider or facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. The provider or facility shall voluntarily refund the Overpayment Amount regardless of the cause, including but not limited to payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Healthy Blue that an Overpayment Amount is due from a provider or facility, the provider or facility must refund the Overpayment Amount within the timeframe specified in the letter notifying the provider or facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, Healthy Blue shall be entitled to offset the unpaid portion of the Overpayment Amount against other claims payments due and payable by Healthy Blue to the provider or facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should the provider or facility disagree with any determination, the provider or facility shall have the right to appeal such

determination under Healthy Blue procedures set forth in this provider manual, on condition that that such appeal shall not suspend Healthy Blue's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Healthy Blue reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud and simplifies the administration of health insurance.

Our company strives to ensure both the health plan and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company, and verify the fax was received.
- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information); such information should be mailed or faxed:

- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked “confidential” and addressed to a specific individual, P.O. Box, or department at our company.
- Our company voice mail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider’s name, address, and tax identification number (TIN) or member’s provider number.

Employee Education about the False Claims Act

As a requirement of the *Deficit Reduction Act* of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the *False Claims Act*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse, and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse, and waste.

Lab Requirements — Clinical Laboratory Improvement Amendments

Healthy Blue is bound by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The purpose of the CLIA program is to ensure laboratories that test specimens in interstate commerce consistently provide accurate procedures and services.

As a result of CLIA, any laboratory that solicits or accepts specimens in interstate commerce for laboratory testing is required to hold a valid license, or letter of exemption from licensure, issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the CLIA requirements.

You must provide Healthy Blue with a copy of your CLIA certificate and notify us if your CLIA status changes. Finally, the CLIA number must be included on each CMS-1500 claim form for laboratory services by any laboratory performing tests covered by CLIA.

Marketing — Prohibited Provider Activities

The state of Kansas is responsible for all marketing during the enrollment process.

Healthy Blue does not influence enrollment in our plan by offering any compensation, reward, or benefit to potential members except for additional health-related services or informational or educational services that have been approved by the state.

Healthy Blue and its subcontractors, including healthcare providers, will not directly solicit potential members and will fully comply with the following marketing restrictions:

- Will not, directly or indirectly, conduct door-to-door, telephonic or other forms of cold-call marketing.
- Will not communicate to a person who is not enrolled in our plan in any way that can be reasonably interpreted as intending to influence the person to enroll in our plan or to influence any enrollment or disenrollment decisions the person might make.
- Will ensure marketing materials do not contain any assertion or statement (whether written or oral) that:
  - The recipient must enroll in Healthy Blue in order to obtain benefits or in order not to lose benefits.
  - We are endorsed by CMS, the federal or state government or similar entity.
- Will not distribute any marketing materials without first obtaining the state's approval.
- Will distribute marketing materials to its entire membership and service area, unless otherwise approved by the state in writing.
- Will not offer the sale of any other type of insurance product as an enticement to enrollment.
- Will ensure our marketing materials and marketing plans are accurate, do not contain false or misleading information, and do not mislead, confuse, or defraud the recipients or the state.
- Will not discriminate against individuals eligible to be covered on the basis of health status or need of health services and will accept individuals in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the contract.
- Will not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

Healthy Blue has stringent review processes in place that ensure that all of our materials meet state requirements.

Providers are permitted to tell members the names of the KanCare MCOs with which they participate; however, providers cannot direct or encourage members to choose a specific MCO.

Health Assessment

We are offering all members the opportunity to complete a health screen following enrollment so we can better identify member needs and refer members to appropriate programs and services. <As part of the health screen process, we are making member responses available for providers to review via the Healthy Blue provider website. After logging in to the secure site, select **Patient & Support**, then **Member Health Assessment**. Follow the instructions as indicated on the website to review the status and results of your member's health assessment. We encourage you to utilize this information as you assess the needs of your patients.>

Permitted Sanctions

In the event a provider fails to meet any performance standard or other requirement or rule of any agency, or any standard or rule existing under applicable law pertaining to the services provided hereunder, we may assess liquidated damages, sanctions or reductions in payment in an amount equal to any penalty actually assessed by the agency or under applicable law against Healthy Blue, due to such performance standard not having been met or due to the breach of such requirement, role or obligation under your provider agreement. Liquidated damages, sanctions, or payment reductions for selected failures of performance will be specifically set forth in

future versions of this provider manual once the state of Kansas issues directives regarding the scope and type of sanctions permitted.

Rest assured, Healthy Blue will work diligently with our network providers to negotiate mutually agreeable corrective action plans and time periods to address any performance issues or failure to meet standards well before any damages or sanctions are put forth.

Records Standards — Member Medical Records

We require medical records to be current, detailed, and organized for effective, confidential patient-care review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.
Our medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data — age, gender, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author
4. Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies — must note prominently:
    - Medication allergies
    - Adverse reactions
    - No known allergies (NKA)
6. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
8. Diagnostic information
9. Medical information — including medication and instruction to patient
10. Identification of current problems:
    - Serious illnesses
    - Medical and behavioral conditions
    - Health maintenance concerns
11. Instructions — including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
12. Smoking/alcohol/substance use — notation required for patients age 12 and older and seen three or more times
13. Consultations, referrals, and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
14. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted

15. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
16. Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member.
- Is legible.
- Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Be legible to someone other than the writer
- Contain information that identifies the member on each page in the medical record
- Contain entries in the medical record that are dated and include author identification (for example, handwritten signatures, unique electronic identifiers, or initials)

Other documentation not directly related to the member

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care including:

- Policies, procedures, and protocols.
- Critical incident/occupational health and safety reports.
- Statistical and research data.
- Clinical assessments.
- Published reports/data.

We may request you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Healthy Blue is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Records Standards — Patient Visit Data

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints.
2. Behavioral health treatment including at-risk factors:
   - Danger to self/others
   - Ability to care for self
   - Affect
   - Perpetual disorders
   - Cognitive functioning
   - Significant social health
3. Admission or initial assessment that must include:
   - Current support systems.
   - Lack of support systems.
4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating either decreased, increased, or unchanged.
5. A plan of treatment including activities, therapies, and goals to be carried out.
6. Diagnostic tests.
7. Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment.
8. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months, or PRN.
9. Referrals and results of all other aspects of patient care and ancillary services.

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for 10 years from the date of service.

Referrals

Members can access the following services **without referrals or precertification**:

- Preventive and routine services
- KAN Be Healthy (EPSDT)
- Routine shots
- Screening or testing for sexually transmitted diseases (including HIV)
- Services from IHS or tribal care providers defined in the Indian Health Care Improvement Act, 25 U.S.C. §§1601, et seq., regardless of whether the provider participates in the Healthy Blue provider network
- Assessment for outpatient substance use disorder services
- Emergency care
- Well-woman services

Your office staff and our members can find PCPs and specialty care providers nearby through our searchable online directory. Upon completion of credentialing and contracting with us, you will receive your user ID and password for our provider website. Nonparticipating providers have the ability to create a user ID and log in to our provider self-service site once one claim has been submitted to Healthy Blue and is processed.

View the online directory by:

1. Logging in to our provider website.
2. Selecting **Referral Info** from the *Tools* menu.
3. Selecting either **Searchable Directory** or **Downloadable Directories** from the *Referral Info* drop-down menu.

When considering recommendation of substance use disorder (SUD) treatments and services to our members, use of Kansas Client Placement Criteria (KCPC) American Society of Addiction Medicine (ASAM) criteria for determining the level of care and treatment is required.

Rights and Responsibilities of Our Members

The following are the rights and responsibilities we share with our members in our member handbook.

Member Rights

Each managed care member is guaranteed certain rights and protections.

Privacy

Be sure their medical records are private and be cared for with dignity and without discrimination. That includes the right to:

- Be treated fairly and with respect.
- Know their medical records and discussions with their doctors will be kept private and confidential.

- Get a copy of their medical records (one copy free of charge); request additional copies of their medical records (they may be charged a fee for these copies); request that the records be amended or corrected.

Take part in making decisions about their healthcare
Consent to or refuse treatment and actively make treatment decisions.

Receive care without limits
Not be stopped or limited if doing so is:

- For someone else's convenience.
- Meant to force them to do something they don't want to do.
- To get back at them or punish them.

Have access to healthcare services
Get healthcare services that are similar in amount and type to those given under fee-for-service Medicaid. That includes the right to:

- Get healthcare services that will complete the right purpose.
- Get healthcare services from doctors who aren't in the health plan; the non-plan doctor must get preapproval,* and if given, the member must get services for the same or less cost than if services were paid by the plan.
- Get services that can help and aren't denied or reduced due to:
  - Diagnosis
  - Type of illness
  - Medical condition

* Preapprovals are not required if they have an emergency medical condition.

Get all information in a way that's easily understood
Be given information in a way they can understand. That includes:

- Enrollment notices.
- Information about their health plan rules, including the healthcare services they can get and how to get them.
- Treatment options and choices, regardless of cost or whether it's part of their benefits.
- A complete description of disenrollment rights at least once a year.
- Notice of any key changes in their benefits at least 30 days before the effective date.
- Information on grievance, appeal, and state fair hearing processes:
  - In a state fair hearing, members may represent themselves or use legal counsel, a relative, a friend or a spokesperson.

If you would like a copy of the member rights and responsibilities, visit the Healthy Blue website or contact Provider Services at **833-838-2595**.

Get information about the Healthy Blue health plan before joining Healthy Blue

Get information about the KanCare program through our plan so that they can make an informed choice. That includes:

- Basic features of KanCare.
- The populations that may or may not enroll in the program.
- Our responsibility to prepare their benefits in a timely manner.

Get information on Healthy Blue services

Get information on KanCare services available through our plan. That includes:

- Benefits we pay for.
- Procedure for getting benefits, including any preapproval requirements.
- Service areas.
- Names, locations, and phone numbers of and non-English languages spoken by current contracted doctors, including, at a minimum:
  - Primary care providers (PCPs)
  - Specialists
  - Hospitals
- Any restriction on their freedom of choice of plan doctors.
- Names of doctors who aren't accepting new patients.
- Benefits not offered by us but that members can get and how to get them; this includes transportation.
- Service utilization (how they use and how we approve services) policies.

Get information on emergency and after-hours services we pay for

Get detailed information on emergency and after-hour care we pay for. That includes:

- What's an emergency medical condition, emergency services, and post-stabilization services (follow-up care after an emergency).
- Post-stabilization rules.
- Notice that emergency services don't need preapproval.
- The process and rules for getting emergency services.
- The locations of emergency rooms and other sites where doctors and hospitals give emergency and post-stabilization care.
- Their right to use any hospital or other setting for emergency care.

Get the Healthy Blue policy on referrals

Get our policy on referrals for specialty care and other benefits not from their PCP.

Get help from the Kansas Department of Health and Environment (KDHE) and the Enrollment Broker

Know the requirements and benefits of the KanCare program.

Get oral interpretation services

Receive oral interpretation services. That includes the right to:

- Get these services for free for all non-English languages, not just those known to be common.
- Be told these services are offered and how to access them.

Exercise their rights without bad effects
Exercise their rights without bad effects on the way we, our doctors or the KDHE treats you. That includes the right to:

- Tell us their complaint or file an appeal about us or the care or services they receive from our doctors.
- Make recommendations about their rights and responsibilities as our member.
- Tell us their concerns or complaints anytime by calling Member Services at **833-838-2593**.

Informed Consent
Members also have the right to:

- Give consent to treatment or care.
- Ask providers about the side effects of care for themselves or their children.
- Know about side effects of care and give consent before getting care for themselves or their children.

Advance Directives
Members also have the right to use advance directives to put their healthcare choices into writing. They may also name someone to speak for them if that member is unable to speak.

Kansas state law has two kinds of advance directives:

- Durable power of attorney for healthcare — names someone to make medical decisions for the member if they are not able to make their own decisions
- Directive to physicians (living will) — tells the doctor/doctors what a member does or does not want if a terminal condition arises or if the member becomes permanently unconscious

Healthy Blue Information
Members also have the right to:

- Receive the necessary information to be a Healthy Blue member in a manner and format they can understand easily.
- Receive a current member handbook and a provider directory.
- Receive assistance from Healthy Blue in understanding the requirements and benefits of the plan.
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change.
- Make recommendations about our rights and responsibilities policies.
- Know how we pay our providers.

Member Responsibilities
As our members, they have the responsibility to:

Learn about their rights
Learn and understand each right they have under the KanCare program. That includes the responsibility to:

- Ask questions if they don’t understand their rights.
- Learn what choices of health plans are available in their area.

Learn and follow their health plan and Medicaid rules

Obey the health plan Medicaid policies and procedures. That includes the responsibility to:

- Carry their ID card at all times when getting healthcare services.
- Let their health plan know if their ID card is lost or stolen.
- Let their health plan know right away if they have a Workers' Compensation claim or a pending personal injury or medical malpractice lawsuit or been involved in an auto accident.
- Learn and follow their health plan and Medicaid rules.
- Make any changes in their health plan and PCP in the ways established by Medicaid and by the health plan.
- Keep scheduled appointments.
- Cancel appointments in advance when they can't keep them.
- Always contact their PCP first for their nonemergency medical needs.
- Be sure they have a referral from their PCP before going to a specialist.
- Understand when they should and shouldn't go to the emergency room.

Tell their doctors about their healthcare needs

Share information about their health status with their PCP and understand all their service and treatment options. That includes the responsibility to:

- Tell their PCP about their health.
- Talk to their doctors about their healthcare needs, and ask questions about the different ways healthcare problems can be treated.
- Help their doctors get their medical records.
- Tell their doctors the truth.
- Follow advice from their doctors, or let the doctor know the reasons the treatment can't be followed as soon as possible.

Take part in making decisions about their health

Actively make decisions relating to service and treatment options, make personal choices and take action to maintain their health. That includes the responsibility to:

- Work as a team with their doctors to decide what healthcare is best for them.
- Understand how the things they do can affect their health.
- Do the best they can to stay healthy.
- Treat doctors and staff with respect.
- Call Member Services if they have a problem and need help.

We provide health benefits to our members on a nondiscriminatory basis, according to state and federal law, no matter what gender, race, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members can visit **https://www.healthybluekansas.com** to access a free online personal health record system to track their health information.

Rights of Our Providers

Each network provider who contracts with Healthy Blue to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is their patient regarding:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or nontreatment.
  - The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal, and state fair hearing procedures.
- Have access to Healthy Blue policies and procedures covering the authorization of services.
- Be notified of any decision by Healthy Blue to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Medicaid/CHIP member, the denial of coverage or payment for services.
- Be free from discrimination where Healthy Blue selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

Satisfaction Surveys

We conduct annual surveys to assess your satisfaction with network participation onboarding processes, communications, education, complaints resolution, claims processing and reimbursements, and utilization management processes, including medical reviews.

We want your feedback; we'll send you advance notice or call to let you know when and how to participate in our surveys.

Support and Training for Providers

Support and Communication Tools

We support you with meaningful online tools and telephone access to Provider Services and our local provider relations representatives (PR reps):

- Provider Services supports your inquiries about member benefits, eligibility, and claims issues.
- Our local PR reps are assigned to all participating providers, facilitate your orientations and education programs, and may visit your office to share information on at least an annual basis.

We also communicate with you and your office staff through newsletters, alerts, and updates posted to our provider website or sent via email, fax, or regular mail.

Training

We conduct initial training of newly contracted providers and provider groups, in addition to ongoing training to ensure compliance with KDHE guidelines and requirements. We provide resource materials through in-person orientation sessions, mailings and on our provider website.

We will announce, in advance and via mail and/or provider website notices, the schedule of these training sessions offered to all providers and their office staff. Training is offered in large-group settings, via webinars or in person as appropriate. We maintain records of providers and staff who attend training and assess participant satisfaction with our training sessions and content as appropriate.

Continuing Medical Education Credits

You and your office staff may be able to obtain continuing medical education (CME) credits by completing our cultural competency and health equity training program and other programs we plan to offer. Continue to check the *Training* section of **https://healthybluekansas.com/provider** and be on the lookout for newsletter stories or announcements about additional CME-qualified courses we plan to make available in the future.

10.TOOLS TO HELP YOU MANAGE OUR MEMBERS

Eligibility (Panel) Listings

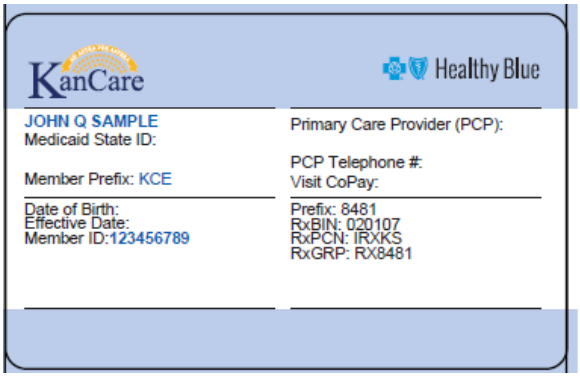
Online panel listings are updated daily to make the most current member information available for review and download. Access your panel listings online through our provider self-service site:

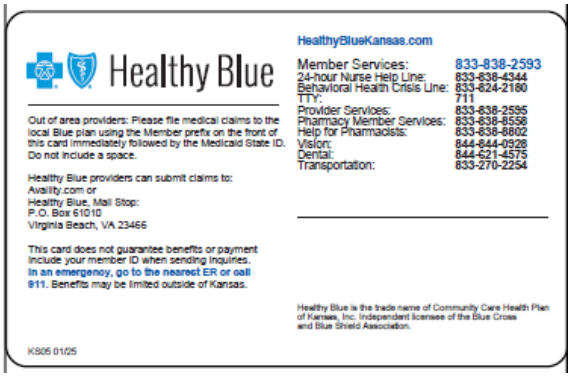
1. Go to **https://healthybluekansas.com/provider** and enter your user ID and password.
2. Select **Eligibility & Panel Listing** in the orange *Tools* menu on the right side of the page.
3. Select **PCP Member Listing** on the list that appears.
4. Select **TIN**, **Provider Name** and **Date Range**.
5. Select the blue **Show Listing** box.
6. Select the blue **Download** button to sort and import the results to an Excel spreadsheet.

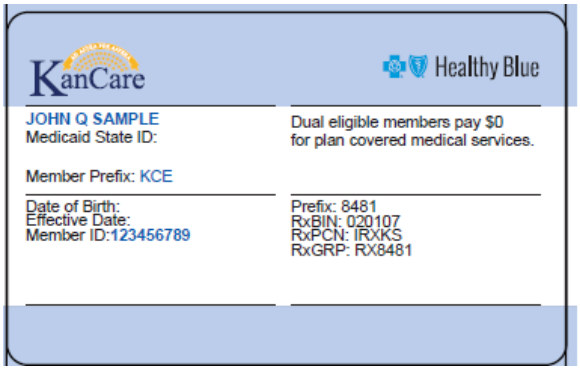
Member panel listings are mailed only upon request — call our Provider Service team or your local Provider Relations representative.

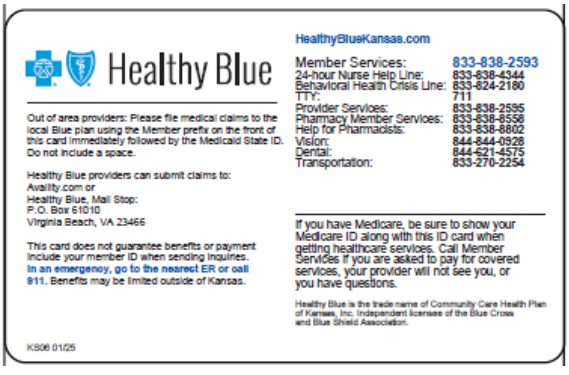
Identification Cards

Via our new mobile ID card smartphone app, available for both iOS and Android users, members can download an image of their current ID cards and fax or email you a copy. Member identification card samples:









Members with Special Needs

The term special needs is used broadly to include members with behavioral health needs or major chronic and complex conditions as well as children and youth with special healthcare needs.

The term special healthcare needs includes any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or limiting condition that requires medical management, healthcare intervention and/or use of specialized services or programs. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity. Healthcare for individuals with special needs requires specialized knowledge, increased awareness and attention, adaptation, and accommodative measures beyond what are considered routine. In general, those with functional impairments resulting from chronic illness, residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), participating in a waiver program, or at high risk for a disabling condition or adverse birth outcome will be engaged in the Healthy Blue healthcare management process and/or service coordination.

A nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Through our care coordination program, we have processes in place to assist with the following:

- Well-child care
- Health promotion and disease prevention
- Specialty care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Long-term services and supports
- Reintegration from institutional settings to communities
- Care coordination systems for assuring children with serious, chronic, and rare disorders receive appropriate diagnostic workups on a timely basis

We coordinate and contract with community organizations such as substance use disorder treatment facilities and long-term care agencies to provide a full range of services for members with special needs.

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

We, with the assistance of our network providers, will identify members who are at risk of or have special needs. The identification will include the application of screening procedures for new members. These will include a review of hospital and pharmacy utilization. We will develop care plans, as appropriate, with the member and their representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is

designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member, upon enrollment, or an existing member, upon diagnosis, requires very complex, highly specialized healthcare services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.
Care coordinators and providers are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

Individuals with special health care needs (ISHCN) means persons who either:

- Have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition.
- Have low to severe functional limitation and also require health and related services of a type or amount beyond that required by individuals generally.

Healthy Blue defines all members who have met a nursing facility level of care as ISHCN (KanCare waiver, Institutional Nursing Facility, and KanCare). Other members may be identified based on referrals from Healthy Blue staff, family members, caretakers, providers, service coordinators, state agencies, or other third parties.

ISHCN require a broad range of primary, specialized medical, behavioral health, and related services. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The Healthy Blue provider network consists of primary, specialized, medical, behavioral, and social services to meet these needs.

Healthy Blue:

- Incorporates into our Member Handbook a description of network providers and programs available to ISHCN.
- Identifies ISHCN among our membership, using the criteria for identification and information provided by the Human Services Department's Medical Assistance Division (HSD/MAD).
- Works with the HSD/MAD to develop and implement written policies and procedures governing how members with multiple and complex physical healthcare needs shall be identified.
- Targets members for the purpose of applying stratification criteria to ISHCN.

Healthy Blue will employ reasonable efforts to identify ISHCNs based at least on the following criteria:

- Individuals eligible for SSI
- Individuals enrolled in the home- and community-based waiver programs such as the KanCare waiver
- Children receiving foster care or adoption assistance support

- Individuals identified by service utilization, clinical assessment, or diagnosis
- Referral by family or a public or community program

Within 10 days of enrolling in our KanCare program, the member will receive a welcome call from Healthy Blue. Healthy Blue manages the service needs of ISHCN through a care coordinator. The care coordinator will work with the member and their family or caregiver to:

- Assess the member's needs including physical health, mental health, social, and long-term support services.
- Develop a service plan (SP). The SP includes but is not limited to:
  - The member's medical history.
  - A summary of the member's current medical and social needs and concerns.
  - Short- and long-term care needs and goals.
  - A list of required services and how often these services are needed.
  - Details on who will provide these services.
  - Information about KanCare and 1915(c) waiver services.
  - A list of specific waiver service network providers in your area from which the member can choose.
- Help arrange timely access to a wide range of providers and services related to ISHCN, including but not limited to:
  - Direct access to KanCare specialty providers as needed.
  - Rehabilitation therapy services.
  - Utilization management services.
- Help arrange other services given outside the SP as needed.
- Review the member's care needs and help them with access to care, specialty referrals, DME and PCP changes.
- Contact the member based on their first health-risk screen to find out if the member has a PCP that can best serve the member based on their healthcare needs.
- Ensure a care coordinator is assigned at the time of the initial health screen if needed.
- Help set up PCP visits and referrals for ongoing case management as needed.
- Teach and allow the member and their family or caregivers to make informed decisions based on the member's SP or treatment plan.

Healthy Blue adheres to clear expectations and requirements related to ISHCN that may include but are not limited to:

- Direct access to specialists as needed.
- Relevant KanCare:
  - Specialty providers for ISHCN.
  - Emergency resource requirements for ISHCN.
  - Rehabilitation therapy services to maintain functionality for ISHCN.
  - Clinical practice guidelines for provision of care and services to ISHCN.
  - Utilization management for services to ISHCN.

Member Grievances

Our members have the right to say they are dissatisfied with Healthy Blue or a provider's service and operations.

Only a member, a member's authorized representative, or a provider acting on behalf of a member with the member's written consent may file a grievance.

A member can file a grievance orally by calling Member Services at **833-838-2593**. They can also file a grievance by mail or by fax. Any supporting documents may be included.

Mail:
Administrative Review and Grievance Department
Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

Fax:
866-387-2968

Member grievances do not involve:

- Medical management decisions.
- Interpretation of medically necessary benefits.
- Adverse determinations.

These are called appeals and are addressed in the various appeals sections of this manual.

Members can file a grievance at any time. We will acknowledge receipt in writing of each oral or written grievance within 10 calendar days.

We investigate each grievance and all of its clinical aspects. Urgent or emergent grievances are resolved within 24 hours of receipt. For nonemergent grievances, we inform the member, investigate the grievance, and resolve it within 30 calendar days from the date we received the grievance. This includes:

- For clinical issues, a written disposition of the grievance within five calendar days of determination.
- For nonclinical issues, a written or oral disposition of the grievance within five calendar days of determination.

Sometimes an extension may be necessary to fully resolve the member's grievance. The state must approve the extension and be informed of how the extension is in the best interest of the member. The extension must not exceed an additional 14 calendar days. The member will receive written notice of the reason for the decision to extend the time frame and how the extension is in their best interest. The member will also be informed of their right to file a grievance if they disagree with the extension. The determination will be issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires. Members do not have the rights to hearings in regard to the dispositions of grievances.

We will notify the member in writing. The notification will:

- Include a description of the grievance.
- Include the date of the grievance resolution.
- Be written in easily understood language of the members preference.
- Be available in State-established Prevalent non-English languages.
- Be available in alternate formats and contain information on how to access those formats.
- Include the names(s), titles(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance.
- Include the disposition of the grievance.
- Include the right to further remedies allowed by the law.
- Include how the grievance process may be continued with Kansas Department of Health and Environment (KDHE) if the member does not agree with the resolution, after the member has exhausted all levels of our
  grievance process.
- Include how the member may be advised or represented by a lay advocate, attorney, or other representative as chosen by the member and agreed to by the representative.

Member Appeals

A member, a member's authorized representative, or a provider acting on behalf of a member with the member's written consent may file an appeal as follows:

- For an appeal of standard service authorization decisions, a member must file an appeal, either orally or in writing, within 60 calendar days of the date on the Healthy Blue *Notice of Adverse Benefit Determination*. An additional three days is allowed for mailing time.
- For an expedited appeal when the member's health requires a decision about services to be made as quickly as possible, a member or member's representative can ask Healthy Blue to make a decision about the expedited appeal within 72 hours after receiving the request. An expedited appeal may be filed in writing or by calling Healthy Blue.
- **Members without waiver benefits** must ask to continue benefits within 10 calendar days of the mailing date on the denial letter. If a member asks us to continue services and it's decided they weren't medically needed or right, the member may have to pay for them. This is not applicable for waiver members unless there has been fraud.
- **Members with waiver benefits** don't have to request for us to continue services. Previously authorized services will continue for 63 calendar days from the date on the denial letter while the member decides if they want to request an appeal. If the member requests an appeal, we'll continue services for 123 calendar days from the date on the appeal decision letter. If the member requests a state fair hearing, we'll continue services until the date of the judge's decision.
- Oral inquiries seeking to appeal adverse benefit determinations will be treated as appeals and be confirmed in writing within five calendar days unless the member or provider requests expedited resolutions.
- Members may contact Member Services at **833-838-2593**.

We will inform the member of the limited time they have to present evidence and allegations of fact or law with expedited resolution. We also will ensure that no punitive action will be taken against a provider who supports an expedited appeal.

The notice of the resolution of the appeal shall be in writing. For notice of an expedited resolution, we will also make reasonable efforts to provide oral notice. We will include the date completed and reasons for the determination in easily understood language. A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the utilization management clinical review or decision-making criteria, will be issued.

If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do so.
- The right to receive benefits while this hearing is pending and how to request them.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action.

Effectuation of Reversed Appeal Resolutions for Services

If the member does not receive services while the appeal is pending: If the managed care organization (MCO) or the state fair hearing (SFH) officer reverses the decision to deny, limit, or delay services and the services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly or as expeditiously as the member's health condition requires.

If the member receives services while the appeal is pending: If the MCO or the SFH officer reverses the decision to deny authorization of services and the member has received the services being disputed during the appeal process, the MCO or the state must pay for those services in accordance with state policy and regulations.

Expedited Appeals

Our expedited appeal process is available upon the member's request or when a provider indicates a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. The member or provider may file an expedited appeal either orally or in writing. No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

No punitive actions are taken against providers who request expedited resolutions or support members' appeals.

Healthy Blue will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within 72 hours after receipt of the expedited appeal request.

If your request is deemed to be a nonexpedited issue, our standard timeline for appeals will apply and the member will receive notification that the appeal is being transferred to the standard appeal process.

Members have rights to file grievances regarding our denial of requests for expedited resolutions. We will inform members of their right to file grievances in the notices of denial.

Continuation of Benefits

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider, as applicable.
- The original period covered by the original authorization has not expired.
- The member continues to be enrolled to a category of eligibility for which the service is a benefit.
- The member requests an extension of benefits.
- HCBS/LTSS members don't have to request for us to continue services. Previously authorized services will continue for 63 calendar days from the date on the denial letter while the member decides if he or she wants to request an appeal. If the member requests an appeal, we'll continue services for 123 calendar days from the date on the appeal decision letter. If the member requests a state fair hearing, we'll continue services until the date of the judge's decision. If a member asks for a Healthy Blue appeal or state fair hearing and has requested benefits to continue, the benefits will continue until one of the following occurs:
  - The member withdraws the appeal.
  - Ten calendar days pass after the notice providing resolution of the appeal is mailed and the resolution is against the member. However, if the member requests a state fair hearing within the 10 calendar-day time frame, the benefits will continue until a state fair hearing decision has been reached.
  - A state fair hearing office issues a hearing decision adverse to the member.
  - The time period or service limits of a previously authorized service has been met.

If the decision is against the member, we may recover the cost of the services the member received while the appeal was pending. For HCBS/LTSS members, if the Healthy Blue appeal is denied or the action taken by Healthy Blue is approved by the Office of Administrative Hearings, members will not have to repay Healthy Blue for services provided during the appeal or state fair hearing, unless fraud has occurred.

Providers may not request continuation of benefits for a member, even if they are acting as a member's authorized representative.

Member Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not kept or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate them about the importance of keeping appointments.
- Encourage them to reschedule the appointment.

For members who frequently cancel or fail to keep appointments, call the Provider Relations team to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCPs.

Member Noncompliance

Contact the Provider Relations team if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

Second Opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, surgery options, or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Once confirmed, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

Note: A second opinion from an expert in child psychiatry is required in order to obtain authorization to prescribe a psychotropic medication for a child under 5 years of age.

When we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Healthy Blue Lock-In Program

The availability and access to controlled substances used for the treatment of acute and chronic health conditions are at an all-time high. This access to healthcare is helping people live longer and healthier lives. However, it can also lead to safety concerns when members are receiving multiple controlled medications that are prescribed by multiple healthcare providers. Because of these concerns, Healthy Blue may identify members who will benefit from additional oversite and coordination through the Lock-In Program.

Members determined to be abusing medical coverage may be restricted to one PCP, one pharmacy, and one hospital (for nonemergency services). The initial lock-in period for all newly identified members is 24 months. A

member who has completed the initial 24-month period and who is subsequently found to have misused benefits for a second time will be placed in extended lock-in with no termination date. Immediate placement in the Lock-In Program can be initiated if a member is convicted of fraud or abuse. Members placed into the Lock-In Program will receive a certified Initial Placement Letter that includes:

- The reasons the member was found to have misused medical or pharmacy benefits.
- Names and locations of assigned providers (PCP, pharmacy, and hospital).
- Notification of the opportunity to change the providers within 10 days after receipt of the letter.
- A statement explaining the member will be held liable for medical bills incurred if the member accesses nonemergent services from a non-lock-in provider.
- A statement explaining the assigned PCP must provide a referral for specialty services prior to the service being rendered.
- Notification of appeal and fair hearing rights.

In the assignment of providers, Healthy Blue will consider geographic location and reasonable travel time, claims evidence that the member has an established provider(s), and any lock-out restrictions.

If the member accesses nonemergent services from an unassigned lock-in provider, the member will be held responsible for those medical bills. The member must always coordinate services through the assigned providers.

For members placed in the Lock-In Program by the Kansas Department of Health and Environment and for whom Healthy Blue is honoring the lock-in status, an extension of the appeal rights for placement into lock-in will not be extended.

Assignment of a Member in the Lock-In Program
Lock-In providers will be notified via written communication of those members who have been assigned to them. The assigned or selected PCP will be notified in writing of the member's placement into the Lock-In Program. The notification will include:

- A list of the member's assigned providers.
- General information regarding the lock-in process and program.
- A Lock-In Referral Form.

Lock-in providers are never required to provide services or medications not supported by medical necessity. The member is expected to actively share in the lock-in responsibility by only receiving healthcare, prescription medications, and hospital outpatient services from the assigned lock-in providers. If the locked-in member fails to follow medical advice, the lock-in providers are not required to provide requested referrals or treatment.

The lock-in physician is the primary prescribing physician. Narcotics and controlled substances should only be prescribed by the lock-in physician or approved by their specific referral.

If the assigned provider is dissatisfied with the member assignment and would like to be removed, the provider, pharmacy, or hospital for nonemergent services may contact Pharmacy Member Services at **833-838-8558**.

The assigned lock-in pharmacy will be the only pharmacy authorized to fill prescriptions for the member. The pharmacy should assist in the member's care by reviewing the prescription history and contacting the prescriber when necessary to ensure coordinated care.

Lock-In Override Exceptions

Pharmacy Issue – Medication Out of Stock
When the assigned lock-in pharmacy does not have medication to fill a prescription, the member will be allowed to have the prescription filled at a pharmacy that has the medication in stock. The assigned lock-in pharmacy or the member may contact Pharmacy Member Services to advise Healthy Blue the member is unable to fill the prescription. Pharmacy Member Services will then locate a pharmacy that has the medication in stock and provide the override.

Provider Issue – Prescription Written by Non-Approved Prescriber
When the member attempts to fill a controlled substance prescription from a nonapproved provider at the assigned lock-in pharmacy, the claim will deny. The assigned lock-in pharmacy or the member may contact Pharmacy Member Services at **833-838-8558** to advise Healthy Blue the member is unable to fill the prescription. Pharmacy Member Services will transfer the member to Case Management to determine if an override is appropriate. The Lock-In team will complete approved overrides.

The member will be restricted to the use of one hospital for nonemergency services. When a lock-in member uses the emergency room and triage reveals the symptoms are nonemergent, the lock-in hospital can decide whether to treat or refer the member to the lock-in physician. It is recommended the lock-in physician instruct the emergency room staff regarding how to handle nonemergent situations for the member.

Referral Requirements
The assigned PCP must provide a referral for specialty services prior to the service being rendered. Providers may obtain the Kansas Lock-In Provider Referral form from Pharmacy Member Services at **833-838-8558**. This form must be completed by the assigned lock-in PCP and sent via fax or email to the lock-in coordinator, as specified on the form.

Suspected Fraud or Abuse
Call the SIU fraud referral hotline at **866-847-8247** or provide written notification should you suspect any incidents of fraud or abuse. Send written documentation to:

Attn: Lock-In Program
Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

11.HOW WE SUPPORT OUR MEMBERS

Nondiscrimination Statement

Healthy Blue does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing aid, benefits, or services to beneficiaries. Healthy Blue does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Healthy Blue does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Healthy Blue may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Healthy Blue provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Healthy Blue representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (**TTY/TTD: 800-537-7697**)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Healthy Blue provides free tools and services to people with disabilities to communicate effectively with us. Healthy Blue also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Healthy Blue has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance with our plan compliance officer via:

- Mail: P.O. Box 61599, Virginia Beach, VA 23466-1599]
- Phone: **833-838-2595**

Equal Program Access on the Basis of Gender
Healthy Blue provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Healthy Blue must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association

with, a member of a protected class (in other words, race, color, national origin, gender, gender identity, age, or disability).

Healthy Blue may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Confidentiality of Information

We maintain procedures to help ensure patients' protected health information (PHI) is kept confidential. PHI is shared only with those individuals who need access to it to conduct some or all of the following functions:

- Utilization management
- Care coordination
- Condition Care discharge planning
- Quality management
- Claims payment
- Pharmacy

Healthy Blue On Call

Healthy Blue On Call is a telephonic, 24-hour triage service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after-hours or on the weekend.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.
- Speak directly with a doctor or a member of the doctor's staff to talk about their healthcare needs.

We encourage you to tell your Healthy Blue patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Members can reach Healthy Blue On Call at **866-864-2544** (Spanish **866-864-2545**). TTY services are available at **711** for members who are deaf or hard of hearing. Language translation services are also available.

Automatic Assignment of Primary Care Providers

When a member is enrolled with Healthy Blue, we automatically assign them to a PCP. Healthy Blue assigns a PCP to members that have KanCare as their primary coverage as well as those with third-party insurance. Members who are dually eligible for Medicare and Medicaid are not assigned a PCP.

PCP auto-assignments are based on proximity to a member's home address, age, gender, and primary spoken language(s). If a member loses coverage for a period of time and is reinstated with Healthy Blue, they will be assigned to the most recent provider that was previously assigned to them.

Members receive an Healthy Blue-issued identification card that displays the PCP name and phone number and other important plan contact information.

Members may elect to change their PCPs at any time. After the member calls Healthy Blue Member Services, the requested changes will become effective no later than the following day and a new ID card will be issued.

Advance Directives

We adhere to the Patient Self-Determination Act and recognize and support the following advance directives:

- Durable power of attorney: lets a member name a patient advocate to act on their behalf
- Living will: lets a member state their wishes on medical treatment in writing

We encourage members age 18 and older to ask you for an Advance Directive Form and education at their first appointment. Please use the state of Kansas-approved Advance Directive form available at **https://www.kmap-state-ks.us/public/forms.asp** and document receipt of their forms in your medical records.

We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine their own care.

A Healthy Blue associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

Care Coordination Services

We offer care coordination services to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment, including care coordination for our members who require long-term services and support. Once we have identified a member's need, our care coordinators work with that member and the member's PCP to identify:

- The level of care coordination needed.
- Appropriate alternate settings to deliver care.
- Healthcare services needed.
- Equipment and/or supplies needed.
- Community-based services needed.
- The best way to foster communication between the member and their PCP.

For members who are hospitalized, our care coordinators also work with the member, our utilization review team, and the PCP or hospital to develop a discharge plan of care and link our member to:

- Community resources
- Our outpatient programs

Member Assessment
Our care coordinators conduct comprehensive assessments to evaluate each person's:

- Medical condition
- Previous pregnancy history
- Current pregnancy status

- Functional status
- Goals
- Life environment
- Support systems
- Behavioral health status
- Ability for self-care
- Current treatment plan

Once we communicate with members or members' representatives and get information from PCPs and specialists, we coordinate our members' current medical and nonmedical needs.

Plan of Service
After the assessment, we:

- Determine the level of need for care coordination services.
- Guide, develop, and implement an individualized plan of service.
- Work with the member, the member's representative and their family, and the provider.

Research has shown us our members comply with their treatment plans more when they can make their own healthcare decisions.

We coordinate all cases of sexually transmitted diseases (STDs) and tuberculosis with local health departments to ensure prevention and limit the spread of disease. We will cooperate with the treatment plan developed by the local health department for these cases.

In addition, we consider our members' needs for:

- Social services such as employment or housing support
- Educational services
- Therapeutic services
- Other nonmedical support services (personal care services [PCS], WIC, and transportation)

We also consider the strengths and needs of our member's family.

We collaborate with other health care professionals to define the best ways to coordinate our member's physical, behavioral health, pregnancy, and social services. We then make sure we forward all written care plans to you by fax or mail.

We welcome your referrals of patients who can benefit from our care coordination support. Call Provider Services or visit our log in to our provider self-service site for more information.

Condition Care

Our Condition Care (CNDC) approach is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions to reduce health disparities and improve health outcomes for all Kansans. Condition Care includes a holistic approach, focusing on the needs of the member through telephonic and community-based resources. Condition Care uses motivational interviewing techniques in conjunction with member self-empowerment and has the ability to manage more than one condition to meet the changing healthcare needs of our member population. Our condition care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder (Adult and Child/Adolescent)
- Schizophrenia
- Substance use disorder

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with smoking cessation and weight management education.

Program features:

- Proactive population identification process
- Program content is based on evidence-based *Clinical Practice Guidelines*
- Collaborative practice models, which include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status

Nine of our Condition Care programs are NCQA-accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Clinical Practice Guidelines are located at **https://healthybluekansas.com/provider.** A copy of the guidelines can be printed from the website.

Who Is Eligible?

Members diagnosed with one or more conditions listed above are eligible for condition care services. As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care coordinators will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their condition. They are provided with continuous education on self-management concepts, which include primary prevention, healthy behaviors, and compliance/monitoring, as well as case/care management for high-risk members, with the goal of creating a person-centered support plan. Providers are given phone and/or written updates regarding patient status and progress.

Condition Care Provider Rights and Responsibilities
Providers have additional rights and responsibilities, such as the right to:

- Obtain information about the organization's services, staff qualifications, and any contractual relations.
- Decline to participate in or work with any of our programs and services on behalf of their patients.
- Be informed how the organization coordinates interventions with care plans for individual members.
- Know how to contact the care coordinator responsible for managing and communicating with their patients.
- Be supported by our organization when interacting with members to make decisions about their healthcare.
- Receive courteous and respectful treatment from the organization's staff.
- Communicate complaints to the organization.

Hours of Operation
Our CNDC care coordinators are registered. They are available Monday through Friday, from 8:30 a.m. to 5:30 p.m. local time. Confidential voice mail is available 24 hours a day.

Contact
You can call a CNDC team member at **888-830-4300**. CNDC program content is located at **https://healthybluekansas.com/provider** under the *Condition* Care section. Providers can go to the provider website and download the CNDC referral form.

Enrollment

Medicaid, CHIP, and waiver population benefits recipients who meet the state's eligibility requirements for participation in managed care:

- Are automatically assigned to an MCO.
- Can change MCOs during a choice period of 90 days after the initial assignments or during the annual open enrollment period.
- Are automatically assigned to PCPs upon auto-assignment to MCOs but may change PCPs thereafter as frequently as desired.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.

Eligible newborns born to members are automatically enrolled with Healthy Blue on the date of birth in most cases. **Dual-eligible members are not assigned to PCPs.**

Interpreter Services

No-cost interpreter services are available to members when calling our Member Services team with questions about our programs, when calling Healthy Blue On Call, during appointments with healthcare providers and during grievance or appeals processes.

For interpretation services during scheduled appointments, call Member Services at **833-838-2593** and be ready to provide the following information:

- Appointment type (for example, PCP, specialist, behavioral health)
- Appointment date/time
- Member name
- Member number
- Provider name
- Provider address

The information will be forwarded to our in-house interpreter manager who will determine the best medium of service needed, either phone or onsite. The manager will coordinate with the member and provider to ensure access to service is available at the time of the appointment. Requests by phone should be accommodated the same day, while on-site interpretation requires a five-day advance notice.

Provider Directories

We offer provider directories for members and referral directories for our network providers in online searchable and hard-copy formats. Since use of these directories is how members identify healthcare providers nearby, it is important that your practice's address, doctors' names, and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting **https://healthybluekansas.com/provider** and logging into your secure account.
- Calling or emailing your local provider relations representative.

Welcome Call

In addition to mailing welcome packets that include PCP selection instructions, handbooks with benefits coverage information and provider directories, we also give new members a welcome call within 10 days of enrollment to:

- Educate them about our services.
- Help them schedule initial checkups.
- Identify any health issues (for example, pregnancy or previously diagnosed diseases).

Well-child Visits Reminder Program

Based on our claims data, we send PCPs a list of members who have not received well-child services according to the schedule. We also mail information to these members encouraging them to contact their PCPs to set up appointments for needed services.

Please note:

1. We list within each report the specific service each member needs.
2. You must render the services on or after the due date in accordance with the American Academy of Pediatrics Periodicity schedule for Kansas.
3. We base our list on claims data we receive before the date shown on each list. Please check to see if you have provided the services after the report run date.

12. QUALITY MANAGEMENT

Program Overview

We have a comprehensive Quality Management program to monitor the demographic and epidemiological needs of the population served.

We evaluate the needs of the health plan's specific population annually, including age/gender/race distribution and inpatient, emergent/urgent care, and office visits by type, cost, and volume. In this way, we can define high-volume, high-risk, and problem-prone conditions.

Quality of Care

We evaluate all physicians, advanced registered nurse practitioners and physician assistants for compliance with the following:

- Medical community standards
- External regulatory and accrediting agencies requirements
- Contractual compliance

We share these reviews to enable you to increase individual and collaborative rates for members. Our quality program includes a review of quality of care issues for all care settings using the following:

- Member grievances
- Reported adverse events
- Other information

Potentially Preventable Adverse Events
According to the Office of the Inspector General (OIG), preventable adverse events are generally caused by:

- Appropriate treatment provided in a substandard way (56 percent).
- Resident's progress not adequately monitored (37 percent).
- Necessary treatment not provided (25 percent).
- Inadequate resident assessment and care planning (22 percent).

Potentially Preventable Events Related to Medication:

- Change in mental status/delirium related to use of opiates and psychotropic medication
- Hypoglycemia related to use of anti-diabetic medication
- Ketoacidosis related to use of anti-diabetic medication
- Bleeding related to use of antithrombotic medication
- Thromboembolism related to use of anticoagulant medication
- Prolonged constipation/ileus/impaction related to use of opiates
- Electrolyte imbalance (including dehydration and acute kidney injury) related to use of diuretic medication
- Drug toxicities including acetaminophen, digoxin, levothyroxine, ACE inhibitors, phenytoin, lithium, valproic acid and antibiotics
- Altered cardiac output related to use of cardiac/blood pressure medication

Potentially Preventable Events Related to Resident Care:

- Falls, abrasions, skin tears, or other trauma related to care
- Electrolyte imbalance (including dehydration and acute kidney injury/insufficiency) associated with inadequate fluid maintenance
- Thromboembolic events related to inadequate resident monitoring and provision of care
- Respiratory distress related to inadequate monitoring and provision of tracheostomy/ventilator care
- Exacerbations of pre-existing conditions related to inadequate or omitted care
- Feeding tube complications (aspiration, leakage, displacement) related to inadequate monitoring and provision of care
- In-house acquired/worsened stage pressure ulcers and unstageable/suspected deep-tissue injuries
- Elopement

Potentially Preventable Events Related to Infections:

- Respiratory infections:
  - Pneumonia
  - Influenza
- Skin and wound infections:
  - Surgical site infections (SSIs)
  - Soft tissue and non-surgical wound infections
- Urinary tract infections (UTIs):
  - Catheter-associated UTIs
- Infectious diarrhea:
  - Clostridium difficile
  - Norovirus

The results they submit to our Quality Management department are incorporated into a profile and include standards for preventive health services.

Quality Management Committee

The Quality Management Committee's (QMC) responsibilities are to:

- Establish strategic direction, monitor, and support implementation of the Quality Management program.
- Establish processes and structure that ensure NCQA compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual Quality Management program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.

- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

Medical Review Criteria

Healthy Blue *Medical Policies*, which are publicly accessible from our website, became the primary benefit plan policies for determining whether services are considered to be: a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Healthy Blue subsidiaries.

A list of the specific Healthy Blue *Clinical UM Guidelines* used will be posted and maintained on the Healthy Blue website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical appropriateness claims edits, and retrospective review.

When applicable, we will use federal law to determine medical necessity. When federal law is not applicable, we will use State Medical Necessity and Appropriate Criteria. When State Medical Necessity and Appropriateness Criteria are not available, we will use MCG inpatient and outpatient medical necessity criteria. When there are no applicable MCG medical necessity criteria, we will use Healthy Blue Clinical Guidelines and Policies. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

Clinical Criteria

The health plan collaborates with network providers to develop clinical practice guidelines of care for our membership that are objective and based on medical evidence and nationally recognized standards of care. The medical advisory committee (MAC) helps us formalize and monitor the clinical practice guidelines and adopt the review criteria.

Clinical Practice Guidelines are located on our website at **https://healthybluekansas.com/provider**. A copy of the guidelines can be printed from the website.

Medical Advisory Committee

Healthy Blue has established a Medical Advisory Committee (MAC) to:

- Assess levels and quality of care provided to members.
- Recommend, evaluate, and monitor standards of care.
- Identify opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions.
- Oversee the peer-review process.
- Advise the health plan administration in any aspect of the health plan policy or operation affecting network providers or members.
- Approve and provide oversight of the peer review process, the Quality Management program, and the Utilization Review program.
- Oversee and make recommendations regarding health-promotion activities.

- Use an ongoing peer review system to:
  - Monitor practice patterns.
  - Identify appropriateness of care.
  - Improve risk-prevention activities.
- Approve clinical protocols/guidelines.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

Credentialing

Healthy Blue will partner with KDHE to facilitate an efficient credentialing process for providers. In accordance with state regulations, providers must register via the KMAP portal, **https://portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate**. If you indicate that you wish to enroll as a provider with Healthy Blue, we will contact you to initiate or complete the contracting and credentialing processes.

The credentialing process evaluates the information gathered and verified and includes an assessment of whether the applicant meets certain criteria relating to professional competence and conduct. We use current NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations, as well as state-specific requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract. This process is completed before a practitioner or provider is accepted for participation in the Healthy Blue network.

Credentialing Requirements

To become a participating Healthy Blue provider, you must hold a current, unrestricted license issued by the state in which you provide services. Healthy Blue may need to request additional credentialing materials, depending on your provider type. Providers must provide all requested supporting documents to complete the contracting and credentialing processes. Healthy Blue will utilize the Kansas Standardized Credentialing Application and supporting documents received via communication from the KMAP Portal.

Healthy Blue's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Healthy Blue's discretion in any way to amend, change or suspend any aspect of Healthy Blue's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to members. Healthy Blue further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);

2. Practitioners who have an independent relationship with Healthy Blue:
    – An independent relationship exists when Healthy Blue directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and
3. Practitioners who provide care to members under Healthy Blue's medical benefits.

The criteria listed above apply to practitioners in the following settings:
1. Individual or group practices;
2. Facilities;
3. Rental networks:
    – That are part of Healthy Blue's primary Network and include Healthy Blue Members who reside in the rental network area.
    – That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Healthy Blue credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Healthy Blue credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Use Disorder
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Use Disorder Clinics
  - Partial Hospitalization – Mental Health and/or Substance Use Disorder
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when **not** associated with another currently credentialed HDO
- Durable Medical Equipment Providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics [ABCOP] or Board of Certification/Accreditation [BOC] or The National Examining Board of Ocularists [NEBO])

Credentialing Committee

The decision to accept, retain, deny, or terminate a practitioner's or HDO's participation in one or more of Healthy Blue's networks or plan programs is conducted by a peer review body, known as Healthy Blue's Credentialing Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels their judgment might otherwise be compromised. A committee member will also disclose if they have been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Healthy Blue's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Healthy Blue may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Healthy Blue will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Healthy Blue will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Healthy Blue will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Healthy Blue will take appropriate action to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a Kansas Standardized Credentialing application through the **KMAP Provider Enrollment Wizard** and ensure all required supporting documents are current. Next, they will need to choose the MCO(s) they would like to pursue a contract. The state will provide the chosen MCOs access to the application and supporting documents to complete contracting and credentialing processes required to join Healthy Blue's network.

Healthy Blue will verify those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.
During the credentialing process, Healthy Blue will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations

Verification Element
• The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed to assess whether practitioners and HDOs continue to meet Healthy Blue credentialing standards ("Credentialing Standards").
All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

Healthy Blue will receive the Kansas Standardized Credentialing application and supporting documentation from the state for review. If the candidate meets Healthy Blue screening criteria, the contracting and credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail

below, in the ***Healthy Blue Credentialing Program Standards*** section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Healthy Blue has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Healthy Blue departments
- Any other information received from sources deemed reliable by Healthy Blue.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Healthy Blue has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Healthy Blue's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Healthy Blue may wish to terminate practitioners or HDOs. Healthy Blue also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Healthy Blue's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Healthy Blue will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Healthy Blue's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Healthy Blue's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, if a practitioner or HDO has been sanctioned, debarred, or excluded from the Medicare, Medicaid or

FEHB programs, has a criminal conviction, or Healthy Blue's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Healthy Blue takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Healthy Blue may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Healthy Blue Credentialing Program Standards

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
D. Meet the education, training and certification criteria as required by Healthy Blue.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Healthy Blue's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
    2. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Healthy Blue education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Healthy Blue review and approval. Reports submitted by delegates to Healthy Blue must contain sufficient documentation to support the above alternatives, as determined by Healthy Blue.
E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
F. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Receipt of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.

4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to their specialty in which they will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that they have applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA/CDS registration.
    d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources:
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Healthy Blue's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if <u>all</u> the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Healthy Blue upon receipt of the required DEA registration; and
d. Healthy Blue will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. they must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and

c. DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Healthy Blue's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

    Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a) Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a) Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
    d. Transcript of applicable pre-doctoral training;
    e. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
    f. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
    g. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Healthy Blue Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.

i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
ii. Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
        ii. American Academy of Nurse Practitioners – Certification Program;
        iii. National Certification Corporation;
        iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
        v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
        vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care.

        These certifications must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review.
    f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the

nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in Healthy Blue's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training, and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All CNM applicants will be certified by either:
        i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
        ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

        These certifications must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Healthy Blue is not required. If the applicant is not certified or if

their certification has expired, the application will be submitted for individual review by the geographic CC.

f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
h. Upon completion of the credentialing process, the CNM may be listed in Healthy Blue's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

10. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Healthy Blue procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional

verification by Healthy Blue is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Healthy Blue Health Plan and submitted for individual review by the CC.

f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Healthy Blue's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Healthy Blue provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PAs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Healthy Blue's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;

9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Healthy Blue standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.
Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Healthy Blue may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Healthy Blue may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Healthy Blue standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care

or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Healthy Blue standards.

A. General Criteria for HDOs:
   1. Valid, current, and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
   2. Valid and current Medicare certification.
   3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. **Note:** If, once an HDO participates in Healthy Blue's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Healthy Blue's other credentialed provider Networks.
   4. Liability insurance acceptable to Healthy Blue.
   5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Healthy Blue's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Healthy Blue Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF

Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Home-and Community-Based Service Providers

To support Healthy Blue LTSS/HCBS program, a set of requirements have been developed that is consistent with applicable 1915(c) HCBS Waiver provider qualification requirements and certification standards identified by the State for HCBS providers and verify compliance with the HCBS settings rule (42 CFR 441.301(c)(4)), as well as any Plan specific requirements.

The scope of this program is defined below:

TYPE 55 HCBS	Waiver/SPECIALTY
Autism Waiver	Family Adjustment Counseling Parent Support and Training Respite Care Financial Management Services

TYPE 55 HCBS	Waiver/SPECIALTY
Frail Elderly (FE) Waiver	Adult Day Care Home and environmental modification services Vehicle modification services Specialized Medical Equipment Personal Care Services Comprehensive Support Financial Management Services Home Telehealth Medication Reminder Nursing Evaluation Visit Ortal Health Services Personal Emergency Response Enhanced Care Services Wellness Monitoring
Intellectual/Developmental Disability (I/DD) Waiver	Adult Day Supports Financial Management Services Children's Integrated Community Supports Medical Alert-Rental Overnight Respite Personal Care Services Residential Supports for Adults and Children Enhanced Care Services Specialized Medical Care Supported Employment Home and Environmental Modification Services Specialized Medical Equipment and Supplies Vehicle Modification Services Wellness Monitoring
Physical Disability (PD) Waiver	Home and environmental modification services Vehicle modification services Specialized Medical Equipment Financial Management Services Home-Delivered Meals Medication Reminder Services Personal Emergency Response System & Installation Personal Care Services Enhanced Care Services

TYPE 55 HCBS	Waiver/SPECIALTY
Technology Assisted (TA) Waiver	Health Maintenance Monitoring Home Modification Financial Management Services Intermittent Intensive Medical Care Personal Care Services Medical Respite Specialized Medical Care
Brain Injury (BI) Waiver	Home and Environmental Modification Services Vehicle Modification Services Specialized Medical Equipment Financial Management Services Home-Delivered Meals Medication Reminder Services Personal Emergency Response System & Installation Personal Care Services Rehabilitative therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy and Occupational Therapy Enhanced Care Services Transitional Living Skills
Serious Emotional Disturbance (SED) Waiver	Parent Support and Training Independent Living/Skills Building Short Term Respite Care Wraparound Facilitation Professional Resource Family Care Attendant Care

Each HCBS/LTSS provider shall maintain appropriate licensure and/or state certification as applicable. HCBS/LTSS providers must not have a current state or federal sanction or exclusion. As required by state or federal requirements, some HCBS/LTSS provider types may have additional requirements noted below. If any other items such as education or training or a background check is required, the provider will be notified:

- Behavior or Cognitive Therapy: Licensed by the Kansas Behavioral Sciences Regulatory Board; evidence of 40 hours of training or at least one (1) year of experience and expertise in brain injury rehabilitation.
- Physical or Occupational Therapy: Licensed by Kansas Board of Healing; evidence of 40 hours of training, and at least one (1) year experience in brain injury rehab.
- Speech/Language Therapy: Licensed by KDHE; evidence of 40 hours of training or at least one (1) year of experience and expertise in brain injury rehabilitation.
- Comprehensive Support – Provider-Directed and Personal Care Services – Provider-Directed Level 1: Must submit proof of doing business in the state and a Surety Bond

In addition, HCBS/LTSS providers are subject to a review at least every three years and are subject to ongoing monitoring related to state licenses or certifications, state and federal sanctions, member complaints, quality of care issues or any other adverse events.

Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:

- Participate in the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director.

The medical director:

1. Assigns a level of severity to the grievance.
2. Invites the cooperation of the physician.
3. Consults with and informs the MAC and peer review committee.
4. Informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken.

We report outcomes to the appropriate internal and external entities, including the Quality Management committee. The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

Early Periodic Screening Diagnostic Treatment (EPSDT)

KAN Be Healthy (KBH) Program Overview

The KAN Be Healthy (KBH) program in Kansas mandates that all Medicaid-eligible, appropriate, and medically necessary services required to correct and improve health conditions, as outlined by the federal Early and Periodic Screening, Diagnostic, Treatment (EPSDT) program, be provided to Medicaid beneficiaries under 21 years of age.

Components of EPSDT:

- **E**arly: Identifying and assessing problems at an early stage.
- **P**eriodic: Conducting health checks at regular, age-appropriate intervals.
- **S**creening: Offering physical, mental, developmental, dental, hearing, vision, and other tests to detect potential issues.
- **D**iagnosis: Performing follow-up diagnostic tests when a risk is identified.
- **T**reatment: Managing, correcting, or reducing health problems.

Coverage of Medically Necessary Services:
Services deemed medically necessary during an EPSDT screening will be covered, even if they are not included in the state's Medicaid plan. Such services, including sleep studies, applied behavior analysis, and elective surgeries, are subject to a prior authorization process.

KBH/EPSDT Screening Requirements:
The KBH screening services encompass hearing, vision, and dental examinations. Each KBH screen must include:

- Medical history
- Physical growth assessment
- Body systems review
- Developmental and emotional evaluation
- Nutritional assessment
- Health education and anticipatory guidance
- Blood lead testing
- Laboratory tests
- Immunizations
- Hearing screening
- Vision screening
- Dental screening

Categories of KBH Examinations:

1. **Medical Screenings (M):**
    a. Must adhere to KBH minimum documentation requirements when billing preventive medicine or office visit CPT codes.
2. **Vision Screenings (V):**
    a. Required at each KBH visit. School vision screenings are separate and not billed by physicians.
3. **Hearing Screenings (H):**
    a. Required at each KBH visit. School hearing screenings are separate and not billed by physicians.
4. **Dental Screenings (D):**
    a. Required at each KBH visit. Only screenings by dentists update the KBH screen. Medical providers meet this requirement by completing the dental section of the KBH form, including details on dentist visits, fluoride varnish application, last dental exam date, or dental referrals.

Screening Schedule:
The State of Kansas Medicaid Agency adheres to the **Bright Futures/AAP Periodicity Schedule** developed by the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) to set recommended timeframes for KBH/EPSDT components. This schedule is suggested for most children, adolescents, and young adults, but additional visits within a year are covered as needed. More information about Bright Futures recommendations is available on the **AAP website**.

Age	Medical	Vision	Hearing	Dental
Birth	M	V	H	
2-5 Days	M	V	H	
2 months	M	V	H	
4 months	M	V	H	
6 months	M	V	H	D
9 months	M	V	H	D
12 months	M (include blood-lead test)	V	H	D
15 months	M	V	H	D
18 months	M	V	H	D
24 months	M (include blood-lead test)	V	H	D
30 months	M	V	H	D
Yearly 3-20	M	V	H	D

Every KBH visit must have all components completed and documented.

Dental screening/attention should be initiated once teeth erupt, as early as 6 months of age.

Immunizations

Appropriate immunizations in accordance with the schedule of pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP) is an important component of the KBH/EPSDT well child visit. The immunization schedule available on CDC's website **Immunization Schedules | Vaccines & Immunizations | CDC**

Healthy Blue's Role and Support

Healthy Blue is dedicated to providing preventive health screenings and enhancing the overall health of children enrolled in KanCare. Given the significant proportion of children within the population, improving the rate of EPSDT screenings is crucial for the well-being of our members.

Member Engagement in Preventive Services

Healthy Blue employs various incentives and communication strategies to encourage preventive services for our child and adolescent members. Below are some of our key initiatives:

- **Healthy Rewards Program:**
  - Offers financial rewards for members participating in various health activities, including objectives aligned with the EPSDT program.
- **Transportation Assistance:**
  - Provides gas mileage reimbursement or non-emergency medical transportation services to facilitate access to care.
- **Phone Outreach:**
  - Conducts phone outreach to encourage preventive care and assists in scheduling appointments as needed.

- **Mail Communications:**
  - Sends birthday mailers to members up to the age of 21 as part of ongoing engagement efforts.
- **Text Message Reminders:**
  - Sends text reminders to parents or guardians of children due for well-child visits, prompting them to schedule and attend the appointments.

Provider Support

In addition to member engagement, Healthy Blue supports providers in several ways:

- **HEDIS Physician Quality Reports:**
  - Sends these reports throughout the year to providers in incentive programs or upon request, highlighting patients who may be behind on their well-child visits or immunizations.
- **EPSDT Participation Reports:**
  - Provides reports that identify moderate to large panels of EPSDT-eligible members with low participation scores, helping providers target communication and increase participation in the EPSDT program.
  - These reports are available upon request to enhance communication and participation efforts.

Healthy Blue remains committed to supporting both members and providers in promoting preventive health services and improving overall health outcomes.

HEDIS Measures Associated with KBH/EPSDT and Billing Codes

Well-Child Visits in the First 15 Months of Life:

- Children should have at least six well-child (KAN Be Healthy) visits with PCP within the first 15 months of life.

CPT Codes	Description
99461	Initial care per day, for normal newborn seen in other than hospital or birthing center
99381	New patient; infant (age younger than 1 year)
99382	New patient; early childhood (age 1 through 4 years)
99391	Established patient; infant (age younger than 1 year)
99392	Established patient; early childhood (age 1 through 4 years)

Lead Screening in Children by 12 and 24 months:

- CMS requires children to have blood lead tests by 12 and 24 months, regardless of score on the KBH-EPSDT Blood Lead Screening Questionnaire.

CPT Codes	Description
83655	Blood lead test completed in practitioner's office.

Well-Child Visits, Ages 3 to 20 Years Old:

- Children/Adolescents/Young Adults should have at least one comprehensive well care (KAN Be Healthy) visit every year with a PCP.

CPT Codes	Description
99382	New patient; early childhood (age 1 through 4 years)
99392	Established patient; early childhood (age 1 through 4 years)
99383	New patient; late childhood (age 5 through 11 years)
99393	Established patient; late childhood (age 5 through 11 years)
99384	New patient; adolescent (age 12-17)
99394	Established patient: adolescent (age 12-17)
99385	New patient; 18 years or older
99395	Established patient: 18 years or older

Childhood and Adolescent Immunizations

Immunizations	Details	CPT and Description
Diphtheria, tetanus, pertussis (DTaP)	At least four doses < age 2	90698 - For intramuscular use with inactivated DTaP-Hib-IPV 90700 - For intramuscular use with inactivated DTaP for younger than age 7 90723 - For intramuscular use with inactivated DTaP-HepB-IPV vaccines
Inactivated poliovirus vaccine (IPV)	At least three doses < age 2	90698 - For intramuscular use with inactivated DTaP-Hib-IPV 90713 - Inactivated IPV vaccine, for subcutaneous or intramuscular use 90723 - For intramuscular use with inactivated DTaP-HepB-IPV vaccines.
Measles, mumps rubella (MMR)	At least one dose < age 2	90707 - Measles, Mumps, Rubella, live vaccine, for subcutaneous use 90710 - Measles, Mumps, Rubella, and Varicella Vaccine, live, for subcutaneous use
Haemophilus influenza type B (Hib)	At least three doses < age 2	90644 - Men serogroups C&Y, Hib type b for children 6 weeks-18 months, IM 90647 - Hib Vaccine, PRP-OMP conjugate (3 dose schedule), for intramuscular use 90648 - Hib Vaccine, PRP-T conjugate (4 dose schedule), for intramuscular use 90698 - For intramuscular use with inactivated DTaP-Hib-IPV 90748 - HepB-Hib combined vaccine, for intramuscular use
Hepatitis B	At least three doses < age 2	90723 - For intramuscular use with inactivated DTaP-HepB-IPV vaccines 90744 - HepB vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use 90748 - HebB-Hib combined vaccine, for intramuscular use
Varicella	At least one dose < age 2	90710 - Measles, Mumps, Rubella, and Varicella Vaccine, live, for subcutaneous use 90716 - Varicella Virus Vaccine, live, for subcutaneous use

Immunizations	Details	CPT and Description
Pneumococcal conjugate	At least four doses < age 2	90670 - For intramuscular use Pneumococcal conjugate vaccine, 13 valent, for children under 5
Hepatitis A	At least one dose < age 2	90633 - Hepatitis A vaccine, pediatric/adolescent dosage (2 dose), for intramuscular use
Rotavirus	At least two or three doses < age 2	90681 - Human, attenuated, 2 dose schedule, live, for oral use 90680 - Pentavalent, 3 dose, live, for oral use
Influenza	At least two doses < age 2 and then one every season	90655 - Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use 90657 - Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use 90685 - Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use 90687 - Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 6 months of age or older, for intramuscular use 90688 - Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
Meningococcal	One on or between ages 11-13	90734 - Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135 (tetravalent), for intramuscular use
Meningococcal B	Two doses given six months apart between ages 16 and 18	90620 - Meningococcal B, OMV. Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use 90621 - Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use
Tetanus, diphtheria, pertussis (Tdap)	One on or between ages 11-13	90715 - Tdap--use in individuals 7 and older, intramuscular use
Human papillomavirus (HPV)	Two doses before age 13	90651 - Human Papillomavirus types 6, 11, 16, 18, 31, 33, 45, 52, and 58, for intramuscular use

In order to be reimbursed for administration of VFC vaccines, the provider must bill the appropriate CPT codes for administration and for the vaccine(s) covered under the VFC program for all children 18 years of age and younger.

Please refer to the **KMAP Professional Manual** for additional information (must use Internet Explorer browser). If you need further assistance, please contact your local PR representative through Healthy Blue.

Additional KBH/EPSDT Screens and Billing Codes

Dental Screenings and Cleanings

Infants should see a dentist after the first tooth erupts but no later than 12 months of age. After 12 months of age, a child should be seen every 6 months for regular screenings and cleanings. The following CPT codes are used for dental screenings only:

- D0120
- D0140
- D0150
- D0170
- D9420

Vision Screenings and Exams

Newborns up to 30 months should have a vision screening at every visit and then annually from three to 20 years. The following CPT codes are used for vision screens only:

- 92002
- 92004
- 92012
- 92014
- 99173

Hearing Screenings

Newborns up to 30 months should have a hearing screening at every visit and then annually from three to 20 years. The following CPT codes are used for hearing screens only.

- 92555
- 92556
- 92557
- 92582
- 92587

All KBH screening forms are on the Kansas Medical Assistance Program (KMAP) website: **KMAP-KBH Provider Information**

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.

APPENDIX A – FORMS

Healthy Blue forms are available for download at **https://healthybluekansas.com/provider**. To request hard copies of these forms, call Provider Services at **833-838-2595**.

KanCare state forms are available at **https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderPublications#prvForms**

APPENDIX B – BEHAVIORAL HEALTH INTEGRATED SERVICES

Overview of Behavioral Health

Our mission is to coordinate the physical and behavioral health care of members, offering a continuum of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for KanCare members. Healthy Blue works collaboratively with healthcare providers, including community mental health centers (CMHCs) and community developmental disability organization (CDDOs), and a variety of community agencies and resources, to successfully meet the needs of members with mental health (MH) conditions and substance use disorders (SUDs), including those participating in waiver programs (for example, SED, autism) and those with intellectual/developmental disabilities (I/DD).

Goals

The goals of the Healthy Blue Behavioral Health (BH) program are to:

- Ensure adequacy of service availability and accessibility to eligible members.
- Assist members and providers to utilize the most appropriate, least restrictive, medical, and behavioral health care in the right place at the right time.
- Promote integration of the management and delivery of physical and behavioral health services to members.
- Achieve the Healthy Blue quality initiatives, including those related to HEDIS, NCQA and the Kansas Department of Health and Environment (KDHE) performance requirements.
- Work with members, providers and community supports to provide tools and an environment that supports members towards their recovery goals.

Objectives

The objectives of the Healthy Blue BH program are to:

- Work with care providers to ensure the provision of medically necessary and appropriate care and services to Healthy Blue's members at the least restrictive level of care, including inpatient care, alternative care settings, and outpatient care, both in and out of network.
- Provide high-quality case management and care coordination services designed to identify member needs and address them in a person-centered, holistic manner.
- Promote continuity and coordination of care among physical and behavioral health care practitioners.
- Maintain compliance with local, state, and federal requirements, as well as accreditation standards.
- Utilize evidence-based guidelines and clinical criteria and promote the use of the same in the provider community.
- Enhance member satisfaction by working with members who are in need to implement an individually-tailored and holistic support and care plan that allows the member to succeed at achieving their recovery goals.
- Enhance provider satisfaction and provider success by developing collaborative and supportive provider relationships built on mutually agreed upon goals, outcomes and incentives to achieve quality and recovery goals through education, technological supports, and the promotion of recovery ideals.

In-network providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the KDHE. These include

mental health services such as psychiatric inpatient hospital services, 24-hour psychiatric residential treatment facilities (PRTFs), outpatient mental health services, case management, psychiatric rehabilitation services and behavioral health crisis services. Also included is substance use disorder (SUD) treatment – inpatient, residential and outpatient.

Recovery and Resiliency

"A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."
— Townsend, W., S. Boyd, G. Griffin, and P. L. Hicks. 2000. *Emerging best practices in mental health recovery*. Columbus: Ohio Department of Mental Health.

"Recovery involves living as well as possible."
—Slade, M. (2009) *Personal Recovery and Mental Illness; A Guide for Mental Health Professionals*. New York: Cambridge University Press.

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
— Substance Abuse and Mental Health Services Administration (SAMHSA, 2011)

Healthy Blue believes physical and behavioral health services should be rendered in a manner that support the recovery of persons experiencing mental illness and enhances the development of resiliency for those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery, as clarified by SAMHSA, include:

1. **Self-direction:** Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines their own life goals and designs a unique path towards those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency as well as their needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in doing so. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of their own destiny and influences the organizational and societal structures in their life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (for example, partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process especially for children and youth (and their families) that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.

- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The guiding principles of a system of care include:
  - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational, and cultural needs.
  - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
  - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
  - Children should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
  - Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
  - Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

General Provider Information

How to Become a Behavioral Health Provider in the Healthy Blue Network
Please see our credentialing information in this provider manual. If you have questions about the Healthy Blue credentialing process before joining our network, call our Network Development team at **888-821-1108**. If you are being recredentialed, you will receive a packet of instructions and contact information for questions or concerns.

Healthy Blue believes the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of BH care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and BH services to meet the needs of the whole person.
- Precertification rules, referrals, claims, and payment processes to help providers reduce administrative time and focus on the needs of members.
- Using reasonable precertification requirements that minimize administrative burden.

Provider Types and Specialties
Please refer to our Behavioral Health Provider Type/Specialty Taxonomy Crosswalk by logging in at **https://healthybluekansas.com/provider** and navigating to the *Reference & Training* section for reimbursement information by provider type and specialty codes recognized.

Border City Providers

Some cities outside of the state of Kansas but within 50 miles of the Kansas border are designated as border cities (please see the KMAP Provider Manual at **https://www.kmap-state-ks.us/Public/providermanuals.asp** for more details). Eligible providers practicing outside of Kansas but within a border city-designated area may enroll with Healthy Blue for the provision of services to KanCare members. Such enrollment will not require Kansas licensure, but the provider must meet the licensing requirements of the state in which they are providing the services.

Substance Use Covered Services

T-XIX Funded Services for T-XIX Members		
Service	**State Plan**	**Waiver**
Level I – Outpatient		
Individual Counseling	X	X
Group Counseling	X	X
Level II: Intensive Outpatient Treatment/Partial Hospitalization		
Intensive Outpatient	X	X
Level III - Residential/Inpatient Treatment		
3.1 Reintegration	X	X
3.5 Intermediate	X	X
3.7D - Acute detoxification	X	X
Auxiliary Services		
Assessment/Referral	X	X
Medicaid Case Management	X	X
Peer Support	X	X
Crisis Intervention	X	X

Court ordered/civil commitment services are subject to medical necessity.

Mental Health Covered Services

T-XIX Funded Mental Health Services	**T-XIX Members**	
	State Plan Only Members	**SED Waiver**
Outpatient Therapy and Medication Management Services		
Evaluation and Assessment	X	X
Testing	X	X
Individual Therapy	X	X
Family Therapy	X	X
Group Therapy	X	X
Medication Management	X	X
Medication Administration	X	X
Case Consultation	X	X
Rehabilitation Services (Subject to functional eligibility requirements)		
Community Psychiatric Support and Treatment	X	X
Psychosocial Rehabilitation	X	X

Peer Support	X	X
Crisis Intervention	X	X
Targeted Case Management (Not covered for CHIP members)		
KAN Be Healthy		
Evaluation and Assessment	X	X
Service Plan Development	X	X
SED Waiver Services		
Parent Support and Training		X
Independent Living/Skills Building		X
Short Term Respite Care*		X
Wrap Around Facilitation		X
Professional Resource Family Care*		X
Attendant Care Services		X
Other		
Attendant Care	X	
Case Consultation	X	X

* These services are not covered for members who are in foster care.

PRTFs provide intensive inpatient mental health services to children and youth that meet admission criteria. The multi-disciplinary consultation team may be convened to consider supports and interventions that have previously been in place, identify supports and interventions that have not been in place, and provide recommendations to determine if the child and youth is best served in a community or inpatient setting. Healthy Blue will apply medical necessity criteria upon or prior to admission.

Services Requiring Precertification

Services require precertification and begin after all covered services have been utilized. The following services require precertification:

- Inpatient psychiatric and substance abuse treatment
- Psychiatric residential treatment facility (PRTF) treatment
- Electro-convulsive therapy (ECT)
- Nursing facilities for mental health for eligible members (under age 21, over age 65)
- Autism services:
  - Consultative clinical and therapeutic services
  - Intensive individual supports
  - Interpersonal communication therapy
- Autism Waiver services:
  - Family adjustment counseling
  - Parent support and training
- SED Waiver Services:
  - Parent support and training
  - Independent living/skills building
  - Short-term respite care
  - Wraparound facilitation
  - Attendant care for SED waiver participants
  - Professional resource family care

These services require notification/registration prior to initiation of a new episode of care. Some services require prior authorization for additional services beyond a pre-determined limit. These are as follows:

- Substance use disorder (SUD) services (require notification/preauthorization in KCPC):
  - Level I – 60 hours over six months
  - Level II – 45 days over 15 weeks
  - Level III.1 – 30 days
  - Level III.3 and III.5 – 14 days
  - SUD auxiliary services – assessment and referral, Medicaid case management, SUD peer support, crisis intervention (require notification in KCPC)
- Mental health services (unit = 15 minutes):
  - Psychological/neuropsychological testing – six hours/year
  - Community psychiatric support and treatment (CPST) – 144 units (36 hours) per calendar year
  - Targeted case management – 240 units (60 hours) per calendar year
  - Crisis Intervention/stabilization – re-evaluation required by a QMHP every 72 hours
  - Admission evaluation – five sessions per year (does not require notification or authorization from Healthy Blue)

Services Not Included

The following services are not covered by Healthy Blue but may be covered under fee-for-service Medicaid for T-XIX eligible members (please see the KMAP website at **kmap-state-ks.us**):

- State hospitals for people with intellectual disabilities that are also public intermediate care facilities for people with intellectual disabilities (ICF/IIDs)
- Institution for mental diseases (IMD) for members over 21 and under 65 years of age:
  - School-based services (with some exceptions), early intervention services ordered through an individual education plan (IEP) or independent family services plan (IFSP), local education agencies (LEAs), Head Start facilities, Part C of the Individuals With Disabilities Education (IDEA) Act
- Laboratory services performed by the Kansas Department of Health and Environment
- Nursing facilities for mental health for members over 21 and under 65 years of age
- Prevention services provided under the Substance Abuse Prevention and Treatment (SAPT) Block Grant

Member Records and Treatment Planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in their record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For members in the population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
  - A psychiatric assessment that includes:
  - Description of the presenting problem.
  - Psychiatric history and history of the member's response to crisis situations.
  - Psychiatric symptoms.

  - Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
  - Mental status exam.
  - History of alcohol and drug abuse.
  - **A medical assessment that includes:**
    - Screening for medical problems.
    - Medical history.
    - Present medications.
    - Medication history.
  - **A substance use assessment that includes:**
    - Frequently used over-the-counter medications.
    - Alcohol and other drugs and history of prior alcohol and drug treatment episodes.
    - History reflecting impact of substance use in the domains of the community functioning assessment.
  - **A community functioning assessment or an assessment of the member's functioning in the following domains:**
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
    - Physical health
    - Emotional/behavioral health
    - An assessment of the member's strengths, current life status, personal goals, and needs
- A patient-centered support and care plan, which is based on the psychiatric, medical, substance use, and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- **There must be documentation in every case that the member and, as appropriate, their family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.**
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.
- The treatment/support/care plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified, written in member-friendly language
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent,

de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
  - Signatures of the member as well as family members, caregivers, or legal guardian as appropriate
- Progress notes are written to document status related to goals and objectives indicated on the treatment plans:
  - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
  - A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
  - Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.
- **Healthy Blue will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and asked to submit a plan for meeting the 100-percent requirement.**

Adverse Incident Reporting

Adverse occurrences (for example, sentinel events, major critical events) reporting must be made by each participating provider to all appropriate agencies as required by licensure and state and federal laws within the specified time frames required immediately following the event; these events must be reported into the Adverse Incident Reporting system (AIR) within 24 hours. Examples of adverse occurrences include but are not limited to the following:

- Treatment complications (including medication errors and adverse medication reactions)
- Accidents or injuries to a member
- Morbidity
- Suicide attempts
- Death of a consumer
- Allegations of physical abuse, sexual abuse, neglect, and mistreatment, and/or verbal abuse
- Use of isolation, mechanical restraint, or physical holding restraint
- Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members

Psychotropic Medications

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment. The medical record is expected to reflect such conversations as having occurred.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side effects from medications. This especially includes:

1. Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per FDA and APA guidelines.
2. Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers.

3. Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers.
4. Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers.
5. ECG checks for members placed on medications with risk for significant QT-prolongation.
6. Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, amongst others. Summary guidelines are referenced in Healthy Blue clinical policy guidelines at **https://healthybluekansas.com/provider**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions are expected to be documented in, at minimum, the medical record for the member.

The Healthy Blue Utilization Management Process

Utilization Management Decision Making

Healthy Blue, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.
- Healthy Blue does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Our Behavioral Health Customer Service Staff

Calls to Behavioral Health Customer Service Staff during regular business hours are taken by our experienced team of clinical services technicians (CSTs). CSTs assist providers with routine inquiries about member eligibility, benefits, and claims or with referrals to network providers for your patients. If you are calling about precertification for a service that requires precertification and clinical review, these requests are referred to a member of our clinical staff to initiate a review of the request.
Provider calls after business hours are taken by our Nurse HelpLine staff, who will issue you a reference number for the precertification request. All requests for precertification will be reviewed by appropriate BH staff within decision and notification timeliness standards (see the “Timeliness of Decisions on Requests for Precertification” grid below).

Behavioral Health Access to Care Standards

Healthy Blue will make authorization determinations within time frames that facilitate timely access to care per the standards outlined below. For this to occur, it is critical that Healthy Blue receive all necessary clinical information in a timely manner.

Mental Health (MH) Services	1. Post stabilization: Within one hour from referral for post stabilization services (both inpatient and outpatient) in an emergency room

	2. Emergency: Within three hours for outpatient MH services and within one hour from referral for an emergency concurrent utilization review screen 3. Urgent: 48 hours from referral for outpatient MH services and within 24 hours from referral for an urgent concurrent utilization review screen 4. Planned Inpatient Psychiatric: Referral within 48 hours, assessment and/or treatment within five working days from referral 5. Routine Outpatient: Referral within five days, assessment and/or treatment within nine workdays from referral and/or 10 workdays from previous treatment
Substance Use Disorder (SUD) Services	**Emergency:** Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating. **Urgent:** A service need that is not an emergency and can be met by providing an assessment within 24 hours of the initial contact, and services delivered within 48 hours from initial contact without resultant deterioration in the individual's functioning or worsening of their condition. If the member is pregnant she is to be placed in the urgent category. **Routine:** A service need that is not urgent and can be met by receiving an assessment within 14 calendar days of the initial contact, and treatment within 14 calendar days of the assessment, without resultant deterioration in the individual's functioning or worsening of their condition. **I.V. drug users:** If a Member has used I.V. drugs within the last six months, and they do not fall into the emergency or urgent categories because of clinical need, he or she should be placed in this category. Members who have utilized I.V. drugs within the last six months need to be seen for treatment within 14 calendar days of initial contact. There is no time-standard requirement for the assessment; nor is there an I.V. drug user category in the KCPC.

	These members are categorized as routine but are to receive treatment within 14 days of their initial contact, not within 14 days of their assessment.

Our Clinical Staff

Healthy Blue has assembled a highly trained and experienced team of clinical care managers, case managers and support staff to provide high-quality care management and care coordination services to KanCare members and to work collaboratively with you, our providers. All clinical staff are licensed and are required to have at least three years of prior clinical experience. Our BH medical director is board certified in psychiatry and licensed in Kansas.

How to Provide Notification or Request Preauthorization

- You may provide notification or request prior authorization for mental health services that require preauthorization via phone by calling **833-838-2595** 24 hours a day, 7 days a week, 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call.
- You may request preauthorization via fax. Healthy Blue-approved fax forms can be obtained on our provider website at **https://healthybluekansas.com/provider**. You may request precertification via **Availity.com**.
- If you are a SUD provider, you must utilize the Kansas Client Placement Criteria (KCPC) screening and assessment tool which is based on American Society of Addiction Medicine (ASAM) criteria. For information on using the KCPC system, visit **https://healthybluekansas.com/provider**.

Note: All requests for precertification for psychological and neuropsychological testing beyond the six-hour initial limit should be submitted electronically via **Availity.com**. If you prefer to paper fax, see the ***Provider Forms*** section). Psychological/neurological testing request forms can also be mailed to:

Behavioral Health Department
Healthy Blue
P.O. Box 62509
Virginia Beach, VA 23466-2509

Healthy Blue Clinical Criteria

- Healthy Blue utilizes clinical criteria to evaluate the medical necessity of requests for care and services as follows:
  - Mental health – Behavioral Health Medical Policies and Clinical UM Guidelines
  - Substance use disorder – Kansas Client Placement Criteria (KCPC), which is based on American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Additional level of care criteria will be used for services not included in the Behavioral Health Medical Policies and Clinical UM Guidelines or KCPC ASAM criteria sets (for example, HCMS waiver services). For more information about additional criteria in use by Healthy Blue, visit **https://healthybluekansas.com/provider**.
- All criteria used by Healthy Blue are approved by the Healthy Blue medical advisory committee and the Healthy Blue national medical policy committee.

For more information about the Behavioral Health Medical Policies and Clinical UM Guidelines, go to **https://healthybluekansas.com/provider**.

Behavioral Health Medical Necessity Determination and Peer Review

- When a provider requests initial or continued precertification for a covered BH service, Healthy Blue utilization managers obtain necessary clinical information and review it to determine if the request appears to meet applicable medical necessity criteria.
- If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by a Healthy Blue BH medical director or other appropriate practitioner as part of the peer review process.
- The Healthy Blue reviewer or the requesting provider may initiate a peer-to-peer conversation to discuss the relevant clinical information.
- If an adverse decision is made by the Healthy Blue reviewer without a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request a conversation within two business days of the issuance of the adverse decision. In this case, we will make a BH medical director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.
- Members, requesting providers, and applicable facilities are notified of any adverse decision by Healthy Blue within notification time frames that are based on the type of care requested, and in conformance with regulatory and accreditation requirements.

Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)

A request for precertification may result in an adverse decision for reasons other than a lack of medical necessity. Reasons for such an adverse decision may include:

- The notification of admission was late. Providers must notify Healthy Blue within 24 hours, or the next business day, of any inpatient admission of a Healthy Blue member.
- The provider failed to request precertification of a service that requires prior precertification.
- The member was ineligible on the date of service.
- The requested service/benefit was a noncovered service/benefit.
- The limit on the benefit has been reached.

Provider Appeals, Grievances and Payment Disputes

If you did not receive a precertification for a requested service and think the decision was in error, see the sections within this provider manual that contain information and instructions on appeals, grievances, and payment disputes.

Avoiding an Adverse Decision

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or the member's benefits. Such information is readily available from Healthy Blue by calling **833-838-2595**.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidence-based, national guidelines. Healthy Blue is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. Peer-to-peer conversations (between a Healthy Blue medical director and the provider clinicians) are one way that Healthy Blue is able to ensure the completeness and accuracy of the clinical information and provide a one-on-one communication about the guidelines as necessary. Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers that are able to appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. Healthy Blue is committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process where possible.

Reducing Risk to Members With Special BH or SUD Health Care Needs Through the Healthy Blue Case Management/Care Coordination Process

- When a member is identified as having special mental health and/or SUD needs requiring some type of intervention to reduce risk, Healthy Blue utilizes the following strategies:
  - Inpatient management – moderate to high-risk hospitalized members:
    - When at-risk members are identified as part of the census management process, the UM staff works with provider discharge planners, the Healthy Blue transitional care coaches, and/or Healthy Blue case managers to develop a discharge plan that maximizes the likelihood of the member making a successful transition back into the community. Key elements of the discharge plan include, but are not limited to:
      - Understanding the characteristics of each particular member (job, family, education, social activities, family background, prior service utilization, etc.)
      - In the case of rapid readmissions – an admission that occurs within 30 days of discharge from the same level of care:
        - What has worked in the past in helping this member to stay out of the hospital (for example, medications, treatment plan, services and supports)?
        - What elements of the previous discharge plan did not work and need to be changed?
        - How do medical issues or complications impact treatment plans?
        - What is the involvement of the family in the treatment process and how do the family and other social supports factor into the discharge plan?
        - Are follow-up appointments scheduled prior to discharge?
        - The BH medical director conducts daily UM rounds and participates in complex case rounds to assist in facilitating the member's successful transition back into the community
  - Transitional care – moderate- to high-risk hospitalized members:
    - A transitional care coach collaborates with the UM staff to work with members, their family caregivers, and, when appropriate, the hospital's discharge planning staff to develop a discharge plan. The plan may include:
      - Pre-transition contacts
      - Assisting the member with planning for follow-up care and ensuring that appointments are scheduled, transportation arranged, etc.
      - Post-discharge contacts
      - Medication reconciliation

    - "Red-flag" education for the member and family/caregiver, as appropriate, about potential problems or relapse triggers
    - Disease-specific interventions
  - Transitional care is a short-term intervention strategy with the goals of reducing the member's risk of re-admission and increasing the likelihood that they will make a successful transition back into the community.
- Complex case management:
  - Once a member is identified as having complex case management needs through the identification methods outlined above, the case manager attempts to engage the member to conduct an assessment to determine the member's care management needs.
  - The case manager works with the member and the member's family/caregiver as appropriate to identify goals that are expressed in member-friendly language.
  - The care plan includes interventions that are agreed upon to achieve the member's goals.
  - The case manager also obtains input from the member's PCP and other specialty providers in developing the care plan.
  - For members with mental health and/or SUD needs, the case manager ensures all needed behavioral health and medical care needs are integrated in a holistic manner by facilitating communication among treating providers and scheduling regular case conferences as required. The case manager may also utilize complex case rounds to obtain input on especially difficult integration issues.
  - The case manager then monitors the member's progress, at regular intervals depending on the member's acuity, in meeting care plan goals. The case manager coordinates care and services with all treating providers and assists the member with community resource referrals. Contacts with the member may be done telephonically or through face-to-face contact, depending on the member's level of acuity.
  - Case management continues until the care plan goals have been substantially met or there is agreement with the member/family/caregiver, as appropriate, that further care management is not indicated.
- Healthy Blue Condition Care:
  - The needs of lower acuity members with mental health or substance use disorder needs may be met through the Condition Care program through some combination of:
    - Lower acuity telephonic care management.
    - Condition Care programs (schizophrenia, major depression, bipolar disorder, or substance use disorder).
    - Referrals to preventive services.
    - Providing them with health promotion materials.

Behavioral Health Drug Utilization Review (DUR) Program

Care Management Technologies (CMT) provides behavioral health prescriber outreach with a special focus on the seriously mentally ill. CMT identifies prescribing practices that deviate from evidence-based medicine. CMT evaluates patient-centric data from multiple sources to create an integrated health profile for coordinating treatment among diverse clinical team members. CMT may contact you about specific patient information. The contact is intended to be informative and is in no way punitive. Please review information provided by CMT on behalf of your Healthy Blue members.

DUR programs have been shown to be effective at improving healthcare quality while reducing medical and/or pharmacy costs.

Post-Discharge Outreach
Healthy Blue providers are required to conduct outreach to all members discharging from inpatient care to encourage the member's attendance at follow-up appointments according to all of the following KDHE standards:

- At least 85 percent of these outreach contacts must occur within 24 to 72 hours of discharge.
- At least 90 percent must occur within one to seven days of discharge.
- 95 percent must occur within one to 10 days of discharge.

Healthy Blue will require providers to maintain records of the results of such outreach efforts and will require reporting of this information to Healthy Blue on a regular basis. Healthy Blue will also conduct on-site audits of member records on at least a quarterly basis.

Providers are also encouraged to use these outreach opportunities to ensure that discharged members/caregivers have been able to fill necessary prescriptions and have access to transportation for follow-up appointments. If members/caregivers need assistance with filling prescriptions, transportation to their appointments or appointment scheduling, they should be encouraged to contact Healthy Blue Member Services at **833-838-2593** for assistance.

Diversion Plans
When clinically indicated, Healthy Blue encourages providers conducting crisis assessments for members at risk for admission to higher levels of care (for example, acute inpatient, PRTF) to carefully consider the opportunity for developing diversion plans, with appropriate member and family/caregiver involvement, to assist the member in safely achieving stabilization at a lower level of care.
The provider should contact the member/family/caregiver, as appropriate, as soon as possible following the diversion to offer needed outpatient services.

Crisis Assessments
Providers delivering crisis assessments to members must initiate a follow-up contact within one business day to any member seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services or referral to any services.

Clinical Practice Guidelines
All providers have ready access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care including ADHD, bipolar disorder for adults and adolescents, major depressive disorder, schizophrenia, and SUDs as well as evidence-based information on the use of psychotropic medications. Please see the provider website at **https://healthybluekansas.com/provider** for more information.

Coordination of Behavioral Health and Physical Health Treatment

- Healthy Blue puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Healthy Blue model of coordinated care include:
  - Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
  - Screening for co-occurring disorders, including:

    - Behavioral health screening by PCPs
    - Medical screening by behavioral health providers
    - Screening of mental health patients for co-occurring SUDs
    - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
  - Screening tools for PCPs and behavioral health providers can be located at **https://healthybluekansas.com/provider**.
  - Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
  - Involving members and their caregivers and family members as appropriate in the development of patient-centered treatment plans, including case management and disease management programs to support the coordination and integration of care between providers
- As a Healthy Blue provider, you are required to notify a member's PCP when a member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
  - Patient demographics
  - Date of initial or most recent behavioral health evaluation
  - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments)
  - Diagnosis and/or presenting behavioral health problem(s)
  - Prescribed medication(s)
  - Behavioral health clinician's name and contact information (See ***Forms*** section)

Training

Healthy Blue must monitor and ensure all participating providers that deliver behavioral health services provide relevant staff with training in accordance with KDHE requirements. As a contracted provider of Healthy Blue, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, Healthy Blue will implement measures to monitor compliance with training requirements.

Additional Training

Healthy Blue will present a series of quarterly training programs for PCPs and behavioral health providers on topics related to the coordination of behavioral health and physical healthcare. It is anticipated that these training events will include the opportunity for providers to obtain CME/CEU credit for participation. Please consult our provider website for a schedule of these training events.

Behavioral Health Consultations for Primary Care Providers

Healthy Blue will provide all contracted PCPs with the ability to consult with a behavioral health specialist. For more information about this and other behavioral health consultation resources, call the BH Helpline at **833-824-2180**.

APPENDIX C – PROCEDURES FOR SKILLED NURSING FACILITIES/NURSING HOMES

For the convenience of nursing facility (NF) providers, we consolidated some very specific information related to the unique services and issues faced by the industry. However, all other sections of our provider manual not described here are also applicable, such as credentialing, recredentialing, quality programs, etc. and are the responsibility of the NF provider, as applicable, based on the scope of services as determined by the provider's licensure.

Members must be in a designated nursing facility level of care (LOC), which is determined by KDHE, in order for Healthy Blue to pay for nursing home treatment. If a member is not in a designated nursing facility LOC, we reserve the right to deny the claim or recoup a paid claim.

Member Benefit Overview

- Healthy Blue members are entitled to room, board, and all ancillary services in an NF based on medical necessity:
  - Healthy Blue determines medical necessity for a short-term placement using established criteria for placement:
    - The NF should request precertification, sometimes referred to as prior authorization (PA) within certain Kansas reference documents, for all such placements that may occur through a discharge from a hospital, member's home, etc.
  - Medical necessity for long-term placements is determined through the state clinical level of care process:
    - Once an individual is approved for clinical and financial eligibility, they will be enrolled in a participating KanCare managed care organization as an institutional NF member.
- Members are entitled to medical and nonmedical leaves of absence (reserve days):
  - Members are allowed up to 10 days per confinement for reservation of a bed if member is admitted to an acute care facility.
  - Members are allowed up to 21 days per admission for reservation of a bed if member is admitted to a state mental hospital, private psychiatric hospital or a psychiatric ward in an acute care facility.
  - Members are allowed a nonmedical leave of absence from an NF with a maximum of 18 days per calendar year.

Member Eligibility

- Reimbursement is contingent upon proof of member eligibility.
- To check eligibility, please use the Healthy Blue eligibility lookup tool to get the most up to date member information. Log in to our provider self-service site, select **Eligibility & Panel Listings** in the *Tools* menu and select **Eligibility**.
- You can also call our Provider Services team to verify member eligibility.
- Providers are required to submit a copy of the Notification of Nursing Facility Admission/Discharge form (MS-2126) to us for all new admissions so we may ensure proper payment of claims. If KDHE has not determined the member meets both functional eligibility and financial eligibility for nursing facility level of care, we are unable to pay the claim.

Member Liability
Medicaid should be the payer of last resort. Healthy Blue will ensure Medicare skilled NF benefits are exhausted prior to utilizing Medicaid. Healthy Blue will assist the facility in convening a discussion with the member and/or responsible party and/or state staff, Adult Protective Services, law enforcement or others as needed.

The NF is responsible for collecting the member liability amount each month and should represent the liability in box 39 on each claim. The payment remitted by Healthy Blue will be reduced by the member liability amount.

The NF should also complete and send an MS-2126 to the case worker so the level of care is updated appropriately in the Kansas Automated Eligibility and Child Support Enforcement System. For additional information, refer to the KMAP Nursing/Intermediate Care Facility Provider Manual. To access, go to the **KMAP Provider Manuals page** and select **Nursing/Intermediate Care Facility** from the *Current Manual Type* drop-down menu.

For circumstances in which the member or responsible party fails to remit payment of the member's liability to the NF, Healthy Blue service coordinators will assist the facility in convening a discussion with the member and/or responsible party and/or state staff, Adult Protective Services, law enforcement or others as needed. The facility administrator or manager should contact the Healthy Blue service coordinator with details regarding the lack of payment of member liability. Details should include:

- The date the last payment was made.
- Discussions held with the member/family to date.
- Correspondence with the member/family to date.
- History of late and/or missed payments, if applicable.
- Any knowledge of family dynamics, concerns regarding the responsible party or other considerations.

Upon approval of NF eligibility, the state's eligibility office will issue a Notice of Action that will identify the patient liability for the first month of eligibility and for the subsequent months. The provider should then collect the patient liability consistent with the Notice of Action.

The following situations and responses are provided to assist you with addressing member liability collection.

Example 1:
The member is approved for institutional NF eligibility as of the 15th of the month:

- State issues Notice of Action for the month for the amount of $500 and for the following month forward of $1,000 per month.
- The facility per diem is $150: 150 x 15 = $2,250.
- The facility collects the $500 patient liability, represents the amount on the claim form in box 39 and bills the MCO for $2,250.
- The MCO will reduce the $2,250 by $500 and remit $1,750.
- If a member is discharged to their home or expires mid-month, the provider may retain the patient liability up to the total charges incurred for the month before discharge.

Example 2:
The member is approved for institutional nursing facility eligibility as of the first of the month and is discharged during the month:

- Patient liability is $1,000.
- Per diem is $150.
- Member is discharged on day 7: 7 x $150 = $1,050:
  - Provider retains all of the patient liability and represents the amount on the claim to the MCO.
- Member is discharged on day 3: 3 x $150 = $450:
  - Provider refunds $550 to the member/family or estate.
  - Provider submits a claim to MCO for three days representing the patient liability collected and MCO reduces the payment by the patient liability and issues a $0 claim payment.

If a member transfers facilities mid-month:

- Eligibility office is contacted regarding impending transfer and expected dates.
- Eligibility office issues a notice of action to the discharging facility for the patient liability it is to collect for the discharge month.
- Eligibility office issues a notice of action to the receiving facility as to the patient liability it is to collect in the first month and for subsequent months.

Healthy Blue Approach to NF Member Liability
Healthy Blue recognizes the unique challenges faced by nursing facility (NF) providers, and may have best practices established, such as collecting an estimated liability prior to coverage approval. For Kansas, Healthy Blue developed intensive training for nursing facilities to address a member/family that is noncompliant in paying the member liability, including facilitating a transfer if the issue cannot be resolved.

The paragraphs below outline our plan for working with the NF and the member/family to resolve such issues.

1. The NF administrator or office manager contacts our service coordinator with details regarding the lack of payment of the member liability including:
   - The date the last payment was made.
   - Discussions held with the member/family to date.
   - Correspondence between the member/family to date.
   - History of late and/or missed payments, if applicable.
   - Any knowledge of family dynamics, concerns regarding the responsible party or other considerations.
2. A Healthy Blue service coordinator and the nursing home social worker, if applicable, discuss the issue with the member, determine the barrier to payment and elicit cooperation:
   - The Healthy Blue service coordinator guides the discussion using pre-determined talking points, including review of the obligation, potential impact to ongoing eligibility, and potential threat to continued residence at the current NF.
   - Healthy Blue talking points will be provided to the state for review and approval as may be applicable.
   - The Healthy Blue service coordinator screens for any potential misappropriation of funds by family or representative payee and refers to Kansas Adult Protective Services intake, as necessary. Healthy Blue will follow the critical incident policy and report to the state as needed.

3. The Healthy Blue service coordinator discusses the issue with the identified responsible party if the member is unable to engage in a discussion regarding payment of the member liability due to cognitive impairment or other disabilities.
4. The Healthy Blue service coordinator or NF social worker will take action if concerns related to misappropriation of funds are raised or suspected and may:
   - Refer the member to Adult Protective Services and/or law enforcement.
   - Initiate a request to the Social Security Administration to change the representative payee status to the person of the member's choosing or the NF.
   - Engage additional family members.
   - Engage Adult Protective Services to establish a conservator or guardian.
5. The Healthy Blue service coordinator will request copies of the cancelled check or other bank document and/or request copy of receipt issued by the NF for payment of liability if the member or responsible party asserts that the required liability has been paid. The service coordinator will present evidence of payment to the NF business office and request confirmation that the issue is resolved. The Healthy Blue service coordinator will also engage the assigned Healthy Blue Provider Relations representative to work with the NF to improve its processes.
6. Healthy Blue will send correspondence that outlines the obligation to pay the member liability, potential impact to ongoing eligibility, and potential threat to continued residence at the current NF if the responsible party is unresponsive and/or living out of the area:
   - The correspondence will be submitted to the state for review and approval as required.
   - The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment.
7. Healthy Blue will take the following actions in conjunction with the NF social worker if member liability remains unsatisfied after the first rounds of discussion or correspondence:
   - Convene a formal meeting with the NF leadership, member and/or responsible party, long-term support services ombudsman as applicable, Adult Protective Services representative as applicable, other representative of the state as applicable, and other parties key to the discussion.
   - Review the patient liability obligation and potential consequences of continued nonpayment.
   - Attempt to resolve the payment gap with a mutually agreed-upon plan.
   - Explain options if the member or responsible party wishes to pursue transfer to another facility or discharge to the community.

   Healthy Blue, together with the NF, will engage in any of the following, as may be applicable if the member liability continues to go unsatisfied:
   - Update and escalate intervention by Adult Protective Services or law enforcement.
   - Refer to the State Medicaid Fraud Control Unit or other eligibility of fraud management staff that the state may designate.
   - Escalate engagement to facilitate a change to representative payee, power of attorney, or guardian.
   - Escalate appointment of a volunteer guardian or conservator.
   - Initiate discharge planning.

Discharge to the Community

Healthy Blue assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests.

If the member or responsible party requests a discharge to the community, the service coordinator will:

- Collaborate with the NF social worker to convene a planning conference with the NF staff and member and/or responsible party to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge. This visit may include an OT evaluation of the community-based setting, a determination of what is needed for continuity of medical care and what physician appointments are necessary once transitioned to the community setting.
- Convene a discharge planning meeting with the member and family using the data complied through discussion with the NF staff as well as the home visit to identify member preferences and goals. This meeting also provides home- and community-based services (HCBS) as applicable.
- Involve and collaborate with community organizations such as community developmental disability organizations (CDDOs), centers for independent living (CILs), area agencies on aging (AAAs) and/or Aging and Disability Resource Centers (ADRCs) in this process to assist members as they transition to the community.
- Finalize and initiate execution of the transition plan.

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the NF social worker, the Healthy Blue service coordinator, and the community-based providers.

Notification Requirements

We request network hospitals notify us within one business day if the level of care for a patient changes. Call the 24/7 Nurse Helpline at **833-838-4344** or send a fax to **800-964-3627**. **This is not the same as requesting a precertification.** Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions.

Documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary. If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with them. The attending emergency room physician or provider who actually treats the member is responsible until, and to determine when, the member is stabilized.

We will mail a Notice of Action to the hospital, the member's PCP, and the member, and include the member's appeal and fair hearing rights and process if coverage is denied.

Please report all adverse incidents to the state of Kansas.

Claims Submission

We offer providers several options to submit claims to Healthy Blue. For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. KDHE will submit your claim information to each MCO through daily 837 batch files.

Paper claims should be submitted directly to Healthy Blue:

Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

You can also submit claims directly on the Healthy Blue website. You can submit claims electronically through Availity using your clearinghouse or practice management software via Electronic Data Interchange (EDI). You also have the option to submit single claim submissions using Availity Essentials under the Claims & Payments menu.

Do not alter or change any billing information (for example, using white out, crossing out, writing over mistakes); altered claims will be returned to the provider with an explanation of the reason for the return. Reimbursement to nursing facilities is based on a per diem methodology according to applicable Kansas Medicaid NF rates in effect on the date of service. The per diem rates are inclusive of all services rendered in the NF.

Requirements:

- Billing of NF services should be on a *UB-04* claim form and denote the revenue codes for routine services. Refer to the **KMAP Nursing/Intermediate Care Facility Manual** for the type of bill that should be used for nursing home billing.
- Reserve days (representing a leave of absence) should be billed with the applicable revenue (REV) code based on Attachment A of your provider agreement. For example:
  - REV 0180 – General Leave of Absence; Inpatient/psychiatric hospital stay
  - REV 0183 – Therapeutic leave of absence; home therapeutic reserve days
  - REV 0185 – Nursing home leave of absence; hospital reserve days
  - REV 0189 – Other leave of absence; noncovered days. No reimbursement for these days
  - Reimbursement for Reserve Days is calculated based on 67 percent of the all-inclusive per diem rate by facility (with the exception of REV 0189)
- Hospice: For members selecting hospice services, the MCO will pay the hospice for the room and board charges, and the hospice will pay the NF in accordance with CMS methodology and at the current applicable Medicaid rate. The provider will need to indicate the NF provider name and NPI on the claim.
- Retroactive adjustments: Healthy Blue understands the unique requirements of nursing facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Healthy Blue website.
- In the event a patient liability amount is added, removed, or modified retroactively, claims will be automatically adjusted.
- Crossover claims procedures: In most cases, when a resident has met the criteria for a Medicare-qualified stay in a certified Medicare bed, the Medicare cost-share will be relayed to Healthy Blue via a crossover file provided to Healthy Blue. Healthy Blue will then process and adjudicate the crossover claim. No further action should be necessary by the provider.
- Corrected claims procedures: A corrected claim code XX7, or a replacement claim code XX8, may be submitted within 365 calendar days of the original claim's *EOP* date. When submitting a corrected claim, ensure the applicable claim code is indicated on the claim form. Also ensure corrected claims contain all applicable dates of service and/or revenue codes for processing.
- The following G codes will be covered to differentiate RN and LPN skilled nursing visits in the home health and hospice settings. Providers will bill the following codes for the acute care home health service plan:

- Service provided by an RN will be coded as G0299 (direct skilled nursing services of a registered nurse [RN] in the home health or hospice setting)
- Service provided by an LPN will be coded as G0300 (direct skilled nursing of a licensed practical nurse [LPN] in the home health or hospice setting).
- Codes G0299 and G0300 will be billed for the first 15 minutes of skilled nursing visits. Providers will continue to use T1002 (RN) and T1003 (LPN) subsequent 15-minute increments of a skilled nursing visit. A combination of one G code and up to three T codes may be billed per visit. The acute care home health service plan limitations still apply.

Claims Processing Approach
In accordance with directives and further clarifications received by KDHE, Healthy Blue will delegate collection of patient liability to the NF and will pay the facility/provider net of the applicable patient liability amount. KDHE retains sole responsibility for determining the member's responsibility for patient liability amounts. Healthy Blue collects this information from the 834-eligibility file received from KDHE.

To ensure Healthy Blue claims analysts process patient liability correctly, a claim extension screen will be used. This claim screen uses the member liability amount provided by KDHE, which includes the amount and applicable date span and automatically applies the appropriate amount based on the dates of service on the claim and amounts applied to any previous claims.

Medical and Nonmedical Absence
Members are allowed up to ten days per confinement for reservation of a bed when a NF, NF/MH or ICF/IID beneficiary leaves a facility and is admitted to an acute care facility when conditions under the reserve day regulations are met. To ensure accurate payment, the NF, NF/MH, or ICF/IID must bill hospital leave days consecutively, beginning with the date of admission.

Members are allowed up to 21 days per admission for reservation of a bed when an NF/MH resident leaves a facility and is admitted to one of the state mental hospitals, a private psychiatric hospital, Prairie View Mental Health Center, or a psychiatric ward in an acute care hospital. To ensure accurate payment, the NF/MH must bill psychiatric leave days consecutively, beginning with the date of admission.

If a beneficiary is not admitted to a hospital but goes to a hospital for observation purposes only, it is considered an approved NF day and **not** a hospital or therapeutic reserve day.

In the event of a **nonmedical** absence from a NF, the facility must report the absence to the local Kansas Department for Children and Families office. These offices do not require MS-2126 forms. A maximum of 18 home-leave days for NFs and 21 days for NF/MHs are allowed per calendar year. Additional days require precertification. Refer to Section 4300 of the KMAP General Special Requirements Manual for requirements. The number of nonmedical reserve days is restricted to 21 days per year for ICF/IID residents.

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not reimburse for medical absences without precertification on the MS-2126 form.

APPENDIX D – PROCEDURES FOR PROVIDERS OF WAIVER SERVICES AND OTHER LONG-TERM SERVICES AND SUPPORTS

Member Eligibility for Waivers

Program eligibility will be determined by the state. This includes financial eligibility and clinical level of care eligibility for the waiver programs.

Procedures for ICF/IID

For the convenience of intermediate care facilities for individuals with intellectual disabilities (ICF/IID) providers, we consolidated some very specific information related to the unique services and issues faced by the industry. However, all other sections of our provider manual not described here are also applicable such as credentialing, recredentialing, quality programs, etc. and are the responsibility of the ICF/IID provider, as applicable, based on the scope of services as determined by the provider's licensure.

Member Benefit Overview

- Healthy Blue members are entitled room, board, and all per diem services and supplies required for a member in an ICF/IID.
- Determination of need for long-term placements is determined through the state and community developmental disability organizations based on the clinical level of care process.
- Once an individual is approved for clinical and financial eligibility, they will be enrolled in a participating KanCare managed care organization as an institutional ICF/IID member.
- The provider will need to obtain precertification for these services retroactively to the date of the approval.
- Members are entitled to medical and nonmedical leaves of absence (reserve days).
- Members are allowed up to 10 days per confinement for reservation of a bed if member is admitted to an acute care facility.
- If a member if not admitted to a hospital but is there for observation purposes only, it is considered an approved ICF/IID day and not a hospital or therapeutic reserve day.
- Members are allowed a nonmedical leave of absence from an ICF/IID with a maximum of 21 days per calendar year. Additional days may be available with prior authorization.

Member Eligibility

- Reimbursement is contingent upon proof of member eligibility.
- To check eligibility, use the Healthy Blue eligibility lookup tool to get the most up-to-date member information. Log in to our provider self-service site, select **Eligibility & Panel Listing** in the *Tools* menu and select **Eligibility**.
- You can also call Provider Services to verify member eligibility.

A list of services requiring precertification and notification can be found in this provider manual and on our provider website. Our provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews:

- Submit precertification requests with all supporting documentation immediately upon identifying an ICF/IID admission or at least 72 hours prior to the scheduled admission.
- For members that enter the facility as "Medicaid Pending," please request precertification as soon as the state approves the Medicaid eligibility and the member's eligibility is reflected on the Healthy Blue website.

Care Coordination

Our care coordination model promotes cross-functional collaboration in the development of member-service strategies. Members identified as waiver members, high-risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Care coordinators accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, caregiver and natural supports.

Since many Healthy Blue members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our care coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available healthcare and community-based resources.

The scope of the care coordination model includes but is not limited to:

- Annual assessments of characteristic and needs of member populations and relevant sub-populations.
- Initial and ongoing assessment.
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers.
- A service coordination approach that is member-centric and provides support, access, and education along the continuum of care.
- A plan that is personalized to meet a member's specific needs and identifies:
  - Prioritized goals.
  - Time frames for re-evaluation.
  - Resources to be utilized including the appropriate level of care.
  - Planning for continuity of care and family participation.
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan which includes the development of self-management strategies to increase the likelihood of improved health and outcomes.

Discharge to the Community

Healthy Blue assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests.

If the member or responsible party requests a discharge to the community, the service coordinator will:

- Collaborate with the social worker to convene a planning conference with the ICF/IID staff to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge.
- Convene a discharge planning meeting with the member and family using the data complied through discussion with the ICF/IID staff as well as the home visit to identify member preferences and goals.
- Involve and collaborate with community originations such as community developmental disability organizations (CDDOs), centers for independent living (CILs) or area agencies on aging (AAAs) in this process to assist members as they transition to the community.
- Finalize and initiate execution of the transition plan.

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the ICF/IID and the Healthy Blue service coordinator.

Claims Submission

We offer providers several options to submit claims to Healthy Blue. For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. KDHE will submit your claim information to each MCO through daily 837 batch files. You can submit claims electronically through Availity using your clearinghouse or practice management software via Electronic Data Interchange (EDI). Paper claims must be submitted direct to Healthy Blue:

Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23466

Do not alter or change any billing information (for example, using white out, crossing out, writing over mistakes); altered claims will be returned to the provider with an explanation of the reason for the return. Reimbursement to ICF/IIDs is based on a per-diem methodology according to applicable Kansas Medicaid ICF/IID rates in effect on the date of service. The per diem rates are inclusive of all services rendered in the ICF/IID.

Requirements:

- Billing of ICF/IID services should be on a *UB-04* claim form and denote the revenue codes for routine services.
- Reserve days (representing a leave of absence) should be billed with the applicable revenue (REV) code based on Attachment A of your provider agreement. For example:
  - REV 0180 – General Leave of Absence; Inpatient/psychiatric hospital stay
  - REV 0183 – Therapeutic leave of absence; home therapeutic reserve days
  - REV 0185 – ICF/IID leave of absence; hospital reserve days
  - REV 0189 – Other leave of absence; noncovered days. No reimbursement for these days
  - Reimbursement for Reserve Days is calculated based on 67 percent of the all-inclusive per diem rate by facility (with the exception of REV 0189)
- Member liability (cost-share) should be reported on the *CMS-1450*/*UB-04* claim form, in box 39. Your claim may be rejected if box 39 is not populated. Even if multiple claims are submitted monthly and the member liability is met with the first claim, subsequent claims should indicate $0 liability.

- Retroactive adjustments: Healthy Blue understands the unique requirements of ICF/IID facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Healthy Blue website and then request an authorization back to the date of eligibility as established by the state. Please note that it may take the state 24 to 48 hours to transmit an updated eligibility to the Healthy Blue.
- Corrected claims procedures: A corrected claim code XX7 or a replacement claim code XX8 may be submitted within 365 calendar days of the original claim's *EOP* date. When submitting a corrected claim, ensure the applicable claim code is indicated on the claim form. Also ensure corrected claims contain all applicable dates of service and/or revenue codes for processing.

Claims Processing Approach
In accordance with directives and further clarifications received by KDHE, Healthy Blue will delegate collection of patient liability to the NF and will pay the facility/provider net of the applicable patient liability amount. KDHE retains sole responsibility for determining the member's responsibility for patient liability amounts. This information is collected by Healthy Blue from the 834 eligibility file received from KDHE. To ensure Healthy Blue claims analysts process patient liability correctly, a claim extension screen is used. This claim screen uses the member liability amount provided by KDHE, which includes the amount and applicable date span and automatically applies the appropriate amount based on the dates of service on the claim and amounts applied to any previous claims.

Inspection of Care Reviews
Inspection of care (IOC) reviews are required for ICF/IIDs and institutions for mental disease (psychiatric state hospitals). This process is performed by KDADS.

Autism Waiver
The Autism waiver is for Medicaid-eligible children from zero through five years of age (at the time of the application) who are diagnosed with an Autism Spectrum Disorder or a Pervasive Developmental Disorder – Not Otherwise Specified.

Services offered under the Autism Waiver include:

- Family Adjustment Counseling
- Parent Support and Training (peer-to-peer)
- Respite Care (agency or self-directed)
- Financial management services

Frail Elderly Waiver
The Frail Elderly (HCBS FE) Waiver is designed to meet the needs of individuals 65 years of age and older who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of individuals with the desire to live outside of an institution.

Services offered under the Frail Elderly Waiver include:

- Adult day care
- Home and environmental modification

- Vehicle modification
- Specialized medical care
- Personal care services (PCS)
- Comprehensive support
- Financial management services
- Home telehealth
- Medication reminders
- Nursing evaluation visit
- Oral health services
- Personal emergency response
- Enhanced care services (ECS) support
- Wellness monitoring

Physical Disability Waiver
The Physical Disability (PD) waiver program is designed for Medicaid-eligible beneficiaries from a minimum of 16 years to under 65 years of age who are determined physically disabled by Social Security standards, excluding beneficiaries with a diagnosis of serious and persistently mentally ill (SPMI), a serious emotional disturbance (SED) or developmentally disabled (DD).

Services offered under the PD Waiver include:

- Home and environmental modification services
- Vehicle modification services
- Specialized medical equipment and supplies
- Financial management services
- Home-delivered meals
- Medication reminder services
- Personal emergency response system and installation
- Personal care services agency-directed
- Personal care services self-directed
- Enhanced care services

Brain Injury Waiver
The Brain Injury (BI) Waiver is designed to meet the needs of beneficiaries who have sustained a traumatically acquired external, non-degenerative, structural brain injury resulting in residual deficits and disability. The BI Waiver is designed to prevent institutionalization. The variety of services listed below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.

Services offered under the BI Waiver include:

- Home and environmental modification services
- Vehicle modification services
- Specialized medical equipment
- Financial management services

- Home-delivered meals
- Medication reminder services
- Personal emergency response system and installation
- Personal care services agency-directed
- Personal care services self-directed
- Enhanced care services (ECS)
- Rehabilitation therapies:
  - behavior therapy
  - cognitive rehabilitation
  - physical therapy
  - speech-language therapy
  - occupational therapy
- Transitional living skills (not mandatory)

Technology Assisted Wavier

The Technology Assisted (TA) Waiver is designed to meet the needs of individuals under 22 years of age who are chronically ill, technology-dependent, and medically fragile. These individuals have an illness or disability that requires the level of care provided in a hospital setting. In the absence of home-care services, they would require admission and prolonged stay in a hospital or medical institution. Additionally, the individual requires both a medical device to compensate for the loss of vital body function and substantial, ongoing care to avert death or further disability. In order to be eligible for services, the individual must be Medicaid-eligible and meet the level of care eligibility criteria.

Services offered under the TA Waiver include:

- Health maintenance monitoring
- Home modification
- Financial management services (FMS)
- Intermittent intensive medical care
- Long-term community personal care services (PCS):
  - Medical service technician (MST)/agency directed
  - Personal care services (PCS)/self-directed
- Medical respite
- Specialized medical care:
  - Licensed practical nurse (LPN)
  - Registered nurse (RN)

Intellectual and/or Developmental Disabilities Waiver

The Intellectual and/or Developmental Disabilities (I/DD) Waiver is designed to meet the needs of individuals ages five or older who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.

Services offered under the I/DD Waiver include:

- Home and environmental modification services
- Vehicle modification services
- Specialized medical equipment and supplies
- Adult Day supports
- Financial management services
- Medical alert-rental
- Overnight respite
- Personal care services (PCS)
- Residential supports
- Enhanced care services (ECS) support
- Specialized medical care
- Supported employment
- Wellness monitoring
- Children's Integrated Community Supports (CHICS)

SED Waiver
The Serious Emotional Disturbance (SED) Waiver is designed to expand Medicaid services for children 4 to 18 years of age who are at risk of admission to a state mental health hospital (SMHH). Additionally, individuals between the ages of 18 to 22 may be eligible for HCBS SED waiver services if intensive community-based services have been in place and continually provided to the individual for at least six months prior to their 18th birthday.

Services offered under the HCBS SED waiver include the following:

- Parent support and training
- Independent living/skills building
- Short-term respite care
- Wraparound facilitation, which is led by a community mental health provider who works with the member and the member's extended family to create an individual plan of care
- Attendant care
- Professional resource family care

Elder Abuse
Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them. Only one in 23 cases is reported. It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.

The types of adult abuse include the following:

- **Neglect** occurs when the basic needs of a dependent adult are not met by a caregiver. Neglect may be unintentional, resulting from the caregiver's lack of ability to provide or arrange for the care or services the adult requires. Neglect also may be due to the intentional failure of the caregiver to meet the adult's needs.

- **Self-neglect** occurs when a dependent adult is unable to care for them or to obtain needed care. The impairments result in significant danger to the adult, and in some situations, deterioration can occur to the point that the adult's life may be at risk.
- **Abuse (physical, sexual, and emotional)** generally involves more extreme forms of harm to the adult, including the infliction of pain, injury, mental anguish, unreasonable confinement or other cruel treatment.
- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of the adult. These are funds paid to the adult or to the caregiver by a governmental agency.

To report abuse, contact the Kansas Department of Children and Family Services' Adult Protective Services, which serves adults aged 18 or older who are abused, neglected, or financially exploited and unable to protect themselves due to mental or physical disabilities or advanced age.

Electronic Visit Verification Systems (EVV)
The Electronic Visit Verification (EVV) system is an automated system that Healthy Blue will utilize to monitor member receipt of certain waiver services as directed by the state of Kansas. The State of Kansas has contracted with Fiserv to provide the Authenticare EVV application to support Electronic Visit Verification. Providers can elect to use Authenticare at no-cost to the provider or elect to use a State-approved third party vendor at the cost of the provider. Each provider required by the state to utilize EVV process for submitting claims for EVV-required services. Providers, either through Authenticare or a third-party vendor, must check in and check out with each service delivery period to verify the member has received the authorized HCBS services.

Applicable provider use of the EVV system will entail checking into the visit using the smartphone application or dialing the system telephonically from the member's home phone number (Interactive Voice Response – IVR) promptly upon arrival to the member's home. This will confirm the identity of the individual provider/staff worker and confirm the arrival at the proper time and location. At the end of the shift or assignment and prior to leaving the member's home, the provider/staff worker will log the departure time and submit information on activities completed and the place of service code.

Electronic Visit Verification will:

- Log the arrival and departure of the individual provider staff person or consumer-directed worker.
- Verify that services are being delivered in the correct location (for example, the member's home) and at the appropriate time.
- Verify the identity of the individual provider staff person or worker providing the service to the member.
- Match services provided to a member with services authorized in the plan of care.
- Ensure that the provider/worker delivering the service is authorized to deliver such services.
- Provider administrators will review and if necessary, manually update visit information to meet submittal requirements. The provider will submit their claims through AuthentiCare. The claims will be submitted to Gainwell and if approved submitted to Healthy Blue (Gainwell routes claims from Authenticare to Healthy Blue):
  - Consumer-directed visits from workers participating in the consumer-directed program are initially submitted to the fiscal employer agent (FEA). The FEA submits the claims to Healthy Blue (via Gainwell).
  - Reconcile submitted claims with service authorizations.

Care Coordination
The Healthy Blue care coordination model promotes cross-functional collaboration in the development of member service strategies. Members identified as waiver members, high-risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service coordinators accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, caregiver and natural supports.

Since many Healthy Blue members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our care coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available healthcare and community-based resources.

The scope of the care coordination model includes but is not limited to:

- Annual assessment of characteristic and needs of member populations and relevant sub-populations.
- Initial and ongoing assessment.
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers.
- Providing a service coordination approach that is member-centric and provides support, access, and education along the continuum of care.
- Establishing a plan that is personalized to meet a member's specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized including the appropriate level of care, planning for continuity of care, and family participation.
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes, which may result in improved quality of life.

Claims Payments
Our processing goal for the KanCare program is to adjudicate all clean claims as quickly as possible. Claims are processed upon arrival and payments are sent to providers five times per week. The turnaround of Healthy Blue is typically well below the state standard for clean claims which is:

- Within 30 calendar days of receipt for clean claims submitted electronically and clean claims received by mail
- Within 14 calendar days of receipt for electronically submitted clean claims for nursing facility providers

If a provider has more than one location, payments are made only to the location they indicated as their primary location.

APPENDIX E – PROCEDURES FOR FINANCIAL MANAGEMENT SERVICE PROVIDERS

Members in the Physical Disability, Brain Injury, Frail Elderly, Technology Assisted, Autism, and Intellectual Development Disability Waivers have a right to choose a financial management services (FMS) provider to assist them to self-direct the care they receive through the waivers.

When a member or member's representative chooses you as an FMS provider, they must be fully informed by you of their rights and responsibilities to:

- Choose and direct support services and the workers who provide the services.
- Perform the roles and responsibilities as employer.
- Understand the roles and responsibilities of the FMS provider.
- Receive initial and ongoing skills training as requested.

Once fully informed, the member or member's representative must negotiate, review, and sign an FMS service agreement developed and made available by KDHE and distributed by the FMS provider. The FMS service agreement will identify the negotiated role and responsibilities of both the member and the FMS provider. It will specify the responsibilities of each party.

The FMS provider has the responsibility to:

- Comply with the provisions of KSA 39-7,100 (home- and community-based services program) and KSA 65-6201 (individuals in need of in-home care; definitions)
- Execute a Provider Agreement with the appropriate state agency.
- Execute a Medicaid provider agreement with the KDHE Division of Health Care Finance.
- Comply with state regulations, KDADS provider agreement requirements, Medicaid provider agreement requirements, policies, and procedures to provide services to eligible beneficiaries.
- Develop and implement procedures, internal controls and other safeguards that reflect Kansas state law (the guiding principles of self-direction) to ensure the member or member's representative, rather than the FMS provider, has the right to choose, direct and control the services and direct support worker(s) who provide them without excessive restrictions or barriers; the procedures, internal controls and other safeguards must be written and must include, at a minimum:
  - A mechanism to process the direct support worker's human resource documentation and payroll in a manner that is efficient and supports the member or member's representative's authority to select, recruit, hire, manage, dismiss, and train direct support workers.
  - Information for the direct support worker that outlines the completion of timekeeping process, wages, benefits, pay days, work hours and the member's self-direct preferences.
  - An assurance that the enrollee or enrollee's representative, not the FMS provider, determines the terms and conditions of work (for example, when and how the services are provided, such as establishing work schedules, determining work conditions; for example, smoking restrictions in the home, conditions for dismissal and tasks to be performed).
  - Internal controls to ensure the member or member's representative is afforded choice and control over workers without excessive restrictions or barriers.
  - A process to respond, within a reasonable time frame, to contact from the member or member's representative informing the FMS provider of the decision to dismiss a particular direct support worker.

  - A process for the self-directing member or member's representative to pay the direct support worker(s) or for the self-directing member or member's representative to delegate the direct support worker(s)payment by direct deposit, first-class mailing, or other means through the FMS provider agency staff.
- Ensure the self-directing member or member's representative and the case manager have the name and contact information of the FMS provider agency staff who can address their issues.
- Assume responsibilities in providing the following administrative services:
  - Establish and maintain all required records and documentation, to include a file for each self-directing member per KDHE regulations, policies, and procedures and in accordance with Medicaid provider requirements; all files must be maintained in a confidential, *HIPAA*-compliant manner.
  - Obtain authorizations to conduct criminal background checks and child abuse and adult registry checks in accordance with applicable waiver requirements.
  - Verify citizenship and legal status of potential direct support workers.
  - Collect and process all required federal, state, and local human resource forms required for employment and the production of payroll.
  - Help the self-directing member or member's representative set the correct pay rate for each direct support worker as allowed under the procedures set by KDHE.
  - Verify and process time worked by direct support worker(s).
  - Compute, withhold, file and deposit federal, state, and local employment taxes for the direct support worker(s).
  - Compute and pay workers compensation as contractually and statutorily required.
  - Approve and pay wages to the direct support worker(s) in compliance with federal and state labor laws.
  - Perform all end-of-year federal, state, and local wage and tax filing requirements as applicable (for example, IRS forms W-2 and W-3, state income tax forms and reporting).
  - Have policies and procedures in place for reporting fraud and/or abuse, neglect, or exploitation by a direct-support worker to the appropriate authority and informing the member or member's representative that if the direct-support worker continues to work for the member, they will no longer be able to serve as the FMS provider agency.
- Ensure each self-directing member is:
  - Maintaining control and oversight of their direct support worker.
  - Aware of the benefits/services available to them.
  - Aware of their requirements and responsibilities to the FMS provider agency.
  - Aware of their requirements and responsibilities to the direct support workers, including an assigned Employment Service Agreement that specifies the responsibilities of the parties in a language/format that is understandable to the worker.
- Ensure each direct-support worker hired by the self-directing member is aware of the:
  - Benefits/services available to them.
  - Employment requirements and job responsibilities of the self-directing member and FMS provider.
- Maintain listing of direct-support workers who are available and desire additional employment.
- Develop, implement, and maintain an internal quality assurance program that monitors for:
  - Self-directed member's satisfaction.
  - Direct-support worker's satisfaction.
  - Correct submission of direct-support worker's time worked.

  - Correct payroll distribution.
- Develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency.
- Maintain evidence of certifications, agreements and affiliations as required by waiver or policy (such as community developmental disability organization [CDDO] affiliation agreements for developmental disabilities services).
- FMS provider must use the State of Kansas Electronic Visit Verification system to receive, review and either accept or deny authorizations for the EVV Covered HCBS-PCS and Home Health Care Services (HHCS). The list of services covered by the State of Kansas EVV program can be found at: EVV Page at the KanCare website: **https://www.kancare.ks.gov/providers/training-resources/electronic-visit-verification**.
  - Refer to page 87 Electronic Visit Verification (EVV) for more information on the responsibilities of all Kansas providers to comply with the State of Kansas EVV requirements.

APPENDIX F – BILLING FOR HCBS WAIVER PROGRAM SERVICES

Information related to billing for the following HCBS waiver programs services are located within this Appendix.

HCBS Waiver Programs:

- Autism (AU)
- Frail Elderly (FE)
- Intellectual/Developmental Disability (I/DD) 5+ years
- Physical Disability (PD)
- Technology Assisted (TA)
- Brain Injury (BI)
- Severe Emotional Disturbance (SED)

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. The table below lists the covered benefits for HCBS waiver program members that is covered and paid for by Healthy Blue. It is subject to change from time to time and is provided herein for quick reference only. Please contact Customer Service or your designated LTSS Provider Relations Representative with any questions you may have regarding benefits.

Services requiring Electronic Visit Verification (EVV) are denoted with a *. Claims for these services require submission via Authenticare. Healthy Blue will not process EVV-required claims unless billed through Authenticare.

For specific billing guidance, refer to the associated waiver manual(s) for the service(s) being provided, available through the Kansas Medical Assistance Program website: **https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManuals**. The HCPCS codes and modifiers below are subject to change; changes will be communicated in advance updated in this manual and other provider communications. Providers are able to use **the KMAP Provider Interactive Tools** to check current HCPCS codes.

HCBS – AUTISM

The HCBS program for children with autism is designed for Medicaid-eligible children from zero through five years of age (at the time of the application) who are at risk of admission to an inpatient psychiatric facility for individuals under 21 years of age.

BENEFIT	HCPCS	LIMITS
Family Adjustment Counseling	S9482 – Individual S9482HQ – Group	Max 48 units per calendar year
Parent Support and Training	T1027 – Individual T1027HQ – Group	Max 120 units per calendar year
Respite Care	T1005*	Max 672 units per calendar year
Financial Management Services	T2040U2*	1 unit equals 1 month

HCBS – FRAIL ELDERLY (FE)

The Home and Community Based Services for the Frail Elderly (HCBS FE) program is designed to meet the needs of beneficiaries 65 years of age and older who would be institutionalized without these services.

BENEFIT	HCPCS	LIMITS
Adult Day Care – <5 hours	S5101	1 unit equals 1-5 hours. Max 1 unit in 24 hours
Adult Day Care – > 5 hours	S5102	1 unit equals >5 hours. Max 1 unit in 24 hours
Home and Environmental Modification Services (HEMS)	S5165	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Vehicle Modification Services (VMS)	T2039	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Specialized Medical Equipment and Sales (SMES)	T2029	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Personal Care Services Level II – Provider Directed	S5125	1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.
Personal Care Services Level III – Provider Directed	S5125UA	1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.
Personal Care Services Level I – Provider Directed	S5130	1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.
Personal Care Services– Self Directed	S5125UD	1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.
Comprehensive Support – Provider Directed	S5135	Max 48 units (12 hours) per day. Cannot exceed 24 hours with other program combo. Cannot be provided at same time as Attendant Care or Enhanced Caret
Comprehensive Support – Self Directed	S5135UD	Max 48 units (12 hours) per day. Cannot exceed 24 hours with other program combo. Cannot be provided at same time as Attendant Care or Enhanced Care
Financial Management Services	T2040U2*	1 unit equals 1 month
Home Telehealth	S0317	1 unit equals 1 day
Home Telehealth – Install	S0315	1 unit equals 1 install. Max 2 units per calendar year
Medication Reminder Call/Alarm	S5185	1 unit equals 1 month. Excludes adult care homes

BENEFIT	HCPCS	LIMITS
Nursing Evaluation Visit	T1001	1 unit equals 1 face-to-face visit. Provided by Attendant Care RN or LPN. Max is 1 unit per lifetime.
Personal Emergency Response System – Install	S5160	1 unit equals one install. Max 2 per year
Oral Health Services		
Personal Emergency Response System – Rental	S5161	1 unit equals 1 month
Enhanced Care Services	T2025	1 unit equals one sleep cycle. Not to exceed 12 hours in 24-hour period. Only 1 unit in 24-hour period. Not to exceed 24 hours with other program combo
Wellness Monitoring	S5190	1 unit equals 1 face-to-face visit. Limited to one face-to-face visit every 55 days, or less frequently, as determined by the MCO.

HCBS – INTELLECTUAL/DEVELOPMENTAL DISABILITIES

The Home and Community Based Services (HCBS) for those with Intellectual and Developmental Disabilities (I/DD) program is designed to meet the needs of beneficiaries who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall health and safety of those beneficiaries with the desire to live outside of an institution. It is the beneficiary's choice to participate in the HCBS program.

BENEFIT	HCPCS	LIMITS
Residential Supports- Regular Tier 1-5	T2016	1 unit = 1 day. Max of 31 per month. (Cannot be billed with S5125, H0045, & T2025/deny)
Residential Supports- Super Tier 1-5	T2016	1 unit = 1 day. Max of 31 per month. (Cannot be billed with S5125, H0045, T1000, and T1000TD & T2025/deny)
Adult Day Supports	T2021	No benefit limits provider managed
Personal Care Services	T1019 (self-directed)* S5125 (agency-directed)	Limited to a maximum of 12 hours per 24-hour period. The combination of PCS, Enhanced Care Services, and other HCBS services must not exceed 24 hours in one day.
Respite Overnight	H0045*	1 unit = 1 day, 60 days per calendar year. Not allowable with T2016 in same day
Supported Employment	H2023	1 unit = 15 minutes

BENEFIT	HCPCS	LIMITS
Enhanced Care Services	T2025*	1 unit = 1 day (minimum of 6 hours). Max of 31 per month
Specialized Medical Care (RN)	T1000TD*	1 unit = 15 minutes, limited to 12 hours/day (48 units) and 372 hours/month (1,488 units)
Specialized Medical Care (LPN)	T1000*	1 unit = 15 minutes, limited to 12 hours/day (48 units) and 372 hours/month (1,488 units)
Medical Alert Rental	S5161	1 unit = 1 month. Max of 12 per year
Financial Management Services	T2040U2*	1 unit = 1 month. Max of 12 per year
Wellness Monitoring	S5190*	1 unit equals 1 visit. Max 1 per 60 days
Home and Environmental Modification Services (HEMS)	S5165	No benefit limit for I/DD waiver HEMS services
Vehicle Modification Services (VMS)	T2039	No benefit limit for I/DD waiver VMS services
Specialized Medical Equipment and Sales (SMES)	T2029	No benefit limit for I/DD waiver SMES services
Targeted Case Management (State Plan Services)	T1017	1 unit = 15 minutes. Max of 240 units per year

HCBS – PHYSICAL DISABILITY (PD)

The Home and Community Based Services for Physical Disability (HCBS PD) program is designed for Medicaid-eligible beneficiaries from a minimum of 16 years to under 65 years of age who are determined physically disabled by Social Security standards, excluding beneficiaries with a diagnosis of Severe and Persistently Mentally Ill (SPMI), Severely Emotionally Disturbed (SED), or Developmentally Disabled (DD), and who are determined by qualified targeted case managers to need assistance to accomplish the normal rhythms of the day.

BENEFIT	HCPCS	LIMITS
Home and Environmental Modification Services (HEMS)	S5165	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Vehicle Modification Services (VMS)	T2039	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Specialized Medical Equipment and Sales (SMES)	T2029	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Financial Management Services	T2040U2*	1 unit equals 1 month
Home-Delivered Meals	S5170	1 unit equals 1 meal. Max 2 meals per day
Medication Reminder Call/Alarm	S5185	1 unit equals 1 month

BENEFIT	HCPCS	LIMITS
Medication Reminder Dispenser	T1505U6	1 unit equals 1 month
Medication Reminder – Install	T1505	1 unit equals install. Max 1 per year
Personal Emergency Response System – Install	S5160	1 unit equals install. Max 2 per year
Personal Emergency Response System – Rental	S5161	1 unit equals 1 month
Personal Care Services – Agency Directed	S5125U9*	1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month
Personal Care Services – Self Directed	S5125U6*	1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month
Enhanced Care Services	T2025*	1 unit equals 6-12 hours. Only 1 unit in 24-hour period

HCBS – SERIOUS EMOTIONAL DISTURBANCE (SED)

The Home and Community Based Services for Serious Emotional Disturbance (HCBS SED) program is designed for Medicaid-eligible beneficiaries between the ages of 4-18 who experience serious emotional disturbance and who are at risk of inpatient psychiatric treatment. SED Waiver services provide children with special intensive support so that they may remain in their homes and communities.

BENEFIT	HCPCS	LIMITS
Parent Support and Training	S5110 (individual); S5110 TJ (Group)	No benefit limits provider managed
Independent Living/Skills Building	T2038	Limited to services not covered under the state plan.
Short Term Respite Care	S5150	No benefit limits provider managed
Wraparound Facilitation	H2021	No benefit limits provider managed
Professional Resource Family Care	S9485	No benefit limits provider managed
Attendant Care	T1019 HK	No benefit limits provider managed

HCBS – TECHNOLOGY ASSISTED (TA)

The Home and Community Based Services (HCBS) Technology Assisted (TA) program is designed to meet the needs of individuals under 22 years of age who are chronically ill, technology dependent, and medically fragile. These individuals have an illness or disability that requires the level of care provided in a hospital setting. In the absence of home care services, they would require admission and prolonged stay in a hospital or medical institution. Additionally, the individual requires both a medical device to compensate for the loss of vital body function and substantial, ongoing care to avert death or further disability. In order to be eligible for services, the individual must be Medicaid eligible and meet the level of care eligibility criteria.

BENEFIT	HCPCS	LIMITS
Home Modifications	S5165	Max $7,500 lifetime

BENEFIT	HCPCS	LIMITS
Financial Management Services	T2040U2*	1 unit equals 1 month
Health Maintenance Monitoring	T1001	1 unit every 3 months. Service cannot be provided or overlap with T1002, T1000, or T1005
Intermittent Intensive Medical Care	T1002	1 unit equals 15 min. Provided by RN. 4 hours per day max, not to exceed 14 days per month (224 units). Cannot be provided or overlap with T1001, T1000, or T1005
Personal Care Services – Agency Directed	T1004*	1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1,488 units/month
Personal Care Services– Self Directed	T1019*	1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1,488 units/month
Medical Respite	T1005	1 unit equals 15 minutes. Max of 168 hours (672 units) per year. T1005 cannot be billed on same day as T1000
Specialized Medical Care RN/ LPN	T1000	1 unit equals 15 minutes. Max 32 units/8hours per day, not to exceed 160 units/40 hours per week. T1000 cannot be billed on same day as T1005

HCBS – BRAIN INJURY

The Home and Community Based Services (HCBS) Brain Injury (BI) program is designed to meet the needs of beneficiaries who have a documented medical diagnosis of a brain injury.

BENEFIT	HCPCS	LIMITS
Home and Environmental Modification Services (HEMS)	S5165	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Vehicle Modification Services (VMS)	T2039	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Specialized Medical Equipment and Sales (SMES)	T2029	Lifetime combined limit between HEMS, VMS and SMES of $10,000
Behavior Therapy	H0004	1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, & G0153
Cognitive Rehabilitation	97532, 97129, 97130	1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, & G0153
Occupational Therapy	G0152	1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, & G0153

BENEFIT	HCPCS	LIMITS
Physical Therapy	G0151	1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, & G0153
Speech Therapy	G0153	1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, & G0153
Enhanced Care Services	T2025*	1 unit equals one sleep cycle. Max 1 unit in 24-hour period. Combined HCBS program services will not exceed 24 hours
Personal Care Services – Agency Directed	S5125U9*	1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month. Not to be overlapped with other services without plan approval
Personal Care Services – Self Directed	S5125UB*	1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month. Not to be overlapped with other services without plan approval
Personal Emergency Response System – Install	S5160	1 unit equals install. Max 2 per year
Personal Emergency Response System – Rental	S5161	1 unit equals 1 month
Financial Management Services	T2040U2*	1 unit equals 1 month
Home-Delivered Meals	S5170	1 unit equals 1 meal. Max of 2 meals per day
Medication Reminder Call/ Alarm	S5185	1 unit equals 1 month
Medication Reminder Dispenser	T1505UB	1 unit equals 1 month
Medication Reminder Install	T1505	1 unit equals 1 install. Max 1 unit per calendar year
Transitional Living Skills	H2014	1 unit equals 15 min.

DATE SPAN BILLING WITH EXAMPLES

Span billing is utilized to simplify the billing process by consolidating services rendered over multiple days into a single entry, provided they occur within the same calendar month and align with the service requirements. This method helps reduce administrative burden and paperwork. The number of units billed for these dates do not have to be an exact match.

Examples of the correct way to bill with date spans are below.

Example 1: Residential Supports (T2016) has a max of 31 units per month.

- Date Range: 1/1/25-1/31/25
- Units 31
- Billing: You provided service all 31 days of the month. You could bill for all 31 days that took place in which services were rendered.

Example 2: Residential Supports (T2016) has a max of 31 units per month.

- Date Range: 1/1/25-1/31/25
- Units 27
- Billing: You could bill for the 27 days in which Residential Supports were provided that took place between 1/1/25-1/31/25. Service delivery days do not need to be consecutive.

You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/25 through 02/10/25 – this would be two claims, one for January and one for February.

APPENDIX G – SAMPLE PROVIDER AGREEMENT

MEDICAID
PARTICIPATION ATTACHMENT TO THE
HEALTHY BLUE
PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the Healthy Blue Provider Agreement ("Agreement"), entered into by and between Healthy Blue and Provider and is incorporated into the Agreement.

Healthy Blue has entered into a contract with the Kansas Department of Health and Environment ("KDHE") to provide specified services and goods to Medicaid Members under such Government Contract. As such, Healthy Blue is authorized to arrange for the provision of managed health care services to Medicaid Members as more fully set forth in this Attachment. The ultimate purpose of the Agreement and this Attachment is to support KanCare, Managed Care for Medicaid and Children's Health Insurance Programs ("CHIP") and other state or federally funded programs.

To the extent Provider participates in the Medicaid Network pursuant to this Agreement and this Medicaid Participation Attachment, which are both subject to review and approval by the KDHE, as to form, and this Agreement and the Medicaid Attachment are implemented prior to such approval, the parties agree to incorporate into the Agreement any and all modifications required by the KDHE for approval or, alternatively, to terminate this Agreement and this Medicaid Participation Attachment if so directed by the KDHE.
Ok
The Effective Date of this Attachment shall be as defined in the Agreement. The Agreement and this Attachment are subject to the following condition, which must be met in order for the Agreement and this Attachment to be enforceable, to-wit, Healthy Blue must be the recipient of an award for the KanCare 3.0 Program by KDHE. Should this condition not be met, this Agreement and this Attachment are immediately null and void.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement. All terms used in the Agreement and this Attachment, and that are defined by Kansas statutes and State Agency regulations will be used in a manner consistent with any definitions contained in said laws or regulations.

"Clean Claim" means, a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas Health Care Prompt Payment Act, Kansas Statute § 40-2441. In accordance with 42 C.F.R. 447.45, Clean Claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

"Early and Periodic Screening Diagnostic and Treatment ("EPSDT")" means a benefit program of preventive health care and well child examinations with appropriate tests and immunizations, except specifically where excluded. It is called the KAN Be Healthy Program in Kansas.

"KanCare" means Managed Care for Medicaid and Children's Health Insurance Programs ("CHIP") and other state or federally funded programs. All such references to Medicaid Covered Services, Medicaid Member and Medicaid Program shall apply to all services, members and programs covered under KanCare or its successor program or other program designated by a State Agency.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Healthy Blue or a State Agency, including KanCare or its successor program.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Plan's Medicaid Program(s) including but not limited to, those serviced deemed covered through Early and Periodic Screening, Diagnostic and Treatment ("EPSDT").

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Plan's Medicaid Program(s).

"Medically Necessary/Medical Necessity" means, except as otherwise provided by Regulatory Requirements, specifically K.A.R. 30-5-58(ooo), that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

i) Authority. The health intervention is recommended by the treating physician and is determined to be necessary by the Secretary of Health and Human Services or the Secretary's designee ("Secretary");

ii) Purpose. The health intervention has the purpose of treating a medical condition;

iii) Scope. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient;

iv) Evidence. The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in K.A.R 30-5-58(ooo)(3). For existing interventions, effectiveness shall be determined as provided in K.A.R 30-5-58(ooo)(4);

v) Value. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. 'Cost-effective' shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the Secretary. An intervention shall be considered cost effective if the benefits and harms relative to cost represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

For substance use disorder (SUD) services, "Medically Necessary" services are services that are consistent with the ASAM ("American Society of Addiction Medicine") criteria as contained in the Kansas Client Placement Criteria ("KCPC") system.

"State Agency" means Kansas Department of Health and Environment ("KDHE"), Kansas Department for Aging and Disability Services ("KDADS"), or other duly authorized state agency.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Healthy Blue's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Healthy Blue for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Healthy Blue's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Healthy Blue with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise required under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in

accordance with Healthy Blue's Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Healthy Blue's Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Healthy Blue's Policies.

2.3 Provider Responsibility. Healthy Blue shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Healthy Blue may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Healthy Blue pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Healthy Blue's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Healthy Blue or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Healthy Blue.

2.5 Plan Marketing/Information Requirements. Provider agrees to abide by Plan's marketing/information requirements. Provider shall forward to Plan for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Plan or the applicable State Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Healthy Blue shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules.

2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Plan shall provide a system for Providers to contact Plan to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Plan's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of Healthy Blue's participating hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Healthy Blue in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, Provider acknowledges and agrees that Healthy Blue is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s).

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Healthy Blue is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Healthy Blue to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Healthcare Effectiveness Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Healthy Blue with written notice of any material changes to such information.

2.12 Non-Discrimination. In addition to the Provider Non-discrimination provision of the Agreement, to the extent applicable to Provider, Provider shall abide by the federal Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Equal Pay Act of 1963; the Americans with Disabilities Act; and the Civil Rights Act of 1991, the Federal Rehabilitation Act of 1973, the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.), the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111 et seq.) and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Medicaid Member from participation in any aid, care, service or other benefit, or deny any Medicaid Member such services on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion. Provider shall not subject any Medicaid Member to discrimination due to such Medicaid Member's status as a Government Contract beneficiary.

2.13 Appointment Times. Provider agrees to maintain a system to document appointment scheduling times. In addition, Provider shall offer hours of operation that are no less than the hours of operation offered to patients with other insurance coverage, including but not limited to commercial health plans. If Provider is a primary care physician, Provider is encouraged to offer after-hours office care to Medicaid Members on evenings and weekends. Provider shall use reasonable efforts to limit office wait times for appointments to forty-five (45) minutes or less.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within one hundred and eighty (180) days from the date the Health Services are rendered or Plan may refuse payment. If Plan is the secondary payor, the one hundred and eighty (180) day period will not begin until Provider receives notification of primary payor's responsibility. Provider may request an additional thirty (30) days to submit a claim if good cause is shown and Healthy Blue will not unreasonably deny such a request for extension.

3.1.1 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to Healthy Blue, unless otherwise instructed, at no cost to Healthy Blue, Plan or the Medicaid Member, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If Healthy Blue or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred and eighty (180) day period referenced in section 3.1 above, whichever is longer. Provider may request

an additional thirty (30) days to submit a claim if good cause is shown and Healthy Blue will not unreasonably deny such a request for extension. Notwithstanding the requirement timeframe set forth section in 3.1 above, Provider may also submit a corrected Claim or rebilling of a timely filed Claim in accordance with industry standards up to three hundred sixty-five (365) days from the date Covered Services were provided.

3.1.3 Once Healthy Blue determines Plan has any payment liability, all Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Plan's Medicaid Program(s).

3.1.4 Healthy Blue shall pay Provider interest for each month that Healthy Blue has neither processed and fully paid the allowed amount nor processed and denied a submitted Claim or Clean Claim after the time limits in the applicable prompt pay period at the interest rate specified under the applicable Medicaid Program as set forth in K.S.A. 2013 Supp. 39-709. Such interest shall not apply if Provider files duplicate claims prior to the expiration of the adjudication timeframe. If Provider has a Claim that remains unpaid by Healthy Blue after the time limits set forth in this section, Provider may bring a direct cause of action against Healthy Blue for the interest provided for in this section in addition to the amount of the unpaid Claim.

3.1.5 When the KDHE assigns a Medicaid Member to Healthy Blue retroactively, Healthy Blue shall be responsible for paying the historical fee-for-service Claims even if these Claims are past Healthy Blue's timely filing policies. Notwithstanding the foregoing, Claims must be for Medicaid Covered Services and Provider may be required to provide evidence of Medical Necessity, such as medical records.

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Plan has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 Recoupment. In addition to the Recoupment/Offset/Adjustment for Erroneous Payments provision of the Agreement, Healthy Blue shall, when directed by KDHE, recover established overpayments made to Provider by the State Agency for performance or non-performance of activities not governed by the Government Contract.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. sections 1681, 1685-1686, and 1783) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment. In addition, upon execution of the Agreement, Provider shall furnish written verification to Healthy Blue that Provider's laboratory facilities, if any, and those with which it conducts business related to Medicaid Members, have appropriate CLIA certification of registration or waiver and a CLIA identification number. Provider shall notify Healthy Blue in writing of any changes in Provider's CLIA certification status or the

certification status of any laboratory facilities with which Provider conducts business related to Medicaid Members within five (5) business days of any such changes.

4.4 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA). If Provider receives five million ($5,000,000) dollars or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide all detailed information required by the DRA and shall provide a copy of such written policies to all of its employees, contractors and agents. Upon request from Healthy Blue, Provider will submit an attestation to Healthy Blue documenting Provider's compliance with the False Claims Act training requirements set forth in §6032. In addition, if Provider maintains an employee handbook, Provider shall include all information required by the DRA in such employee handbook.

4.5 Certification Regarding Immigration Reform & Control. Provider shall comply with all applicable Regulatory Requirements affecting a person's participation and eligibility in any program or activity undertaken by Healthy Blue pursuant to this Agreement. Provider shall comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by Healthy Blue as well as by Provider or any contracted provider. The usual method of verification is through the Employment Verification (I-9) Form. Any misrepresentation by Provider or any employment of persons not authorized to work in the United States constitutes a material breach and, at the state's option, may subject this Agreement to termination and any applicable damages. The state's Certification Regarding Immigration Reform & Control form is attached hereto as Exhibit A and made a part hereof.

4.6 Treatment of Individuals with Special Needs. In accordance with confidentiality laws, if Provider provides services to Medicaid Members with special needs, Provider agree to develop treatment plans that: (i) ensure that in the process of coordinating care, each Medicaid Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and other Regulatory Requirements related to the confidentiality of protected health information; and (ii) are developed with the Medicaid Member's Primary Care Physician ("PCP"), Medicaid Member's participation, and in consultation with any Specialists, including other health care professionals in compliance with Regulatory Requirements, caring for the Medicaid Member (the Medicaid Member may choose to involve another physician other than their PCP in the development of their treatment plan). PCP and Specialist are defined in the PCS; (iii) are approved by Healthy Blue in a timely manner, if prior authorization of any service in the treatment plan is required; (iv) are in accord with any applicable state quality assurance and utilization review standards; (v) permit direct access to Specialists, including other health care professionals in compliance with Regulatory Requirements, as appropriate; and (vi) require focused coordination of treatment programs.

4.7 Employed or Contracted Individuals. In no event shall Provider employ or subcontract any responsibilities hereunder to any individual who has been excluded from participation under any federal or state health benefits program, including without limitation the Medicaid or Medicare programs. Healthy Blue and Provider shall comply with the requirements specified in 42 CFR Part 438 regarding selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. Current credentialing criteria prohibit Healthy Blue from employing or contracting with individuals on the state or federal exclusion list.

4.8 Prohibited Practices. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from: i) discussing treatment or non-treatment options with Medicaid Members irrespective of Healthy Blue's position on such treatment or non-treatment options or whether such treatment options are Medicaid Covered Services; ii) acting within the lawful scope of such Participating Provider's practice, advising or advocating on behalf of a Medicaid Member for such Medicaid Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered by the Medicaid Member; or iii) advocating on behalf of a Medicaid Member within the utilization review or grievance processes established by Healthy Blue or individual authorization process to obtain Medically Necessary Medicaid Covered Services.

4.9 FQHC/RHC. If Provider is an FQHC/RHC, Healthy Blue shall adhere to federal requirements for reimbursement for FQHC/RHC services. The agreed upon payment from Healthy Blue to the FQHC/RHC is set forth in the PCS. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid Members shall be in compliance with Regulatory Requirements. Healthy Blue shall submit the name of Provider and the number of Medicaid encounters paid to Provider by month of services to the Medicaid Program for reasonable cost based reconciliation purposes. As set forth in the PCS, Healthy Blue shall pay

Provider the Encounter Rate based on the Prospective Payment System ("PPS") rate in effect on the date of service for each encounter.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.2 Medicaid Hold Harmless. Pursuant to Kansas Statute § 40-3209(b), Provider acknowledges and agrees that Medicaid Members shall not be held liable for debt due to insolvency of Healthy Blue or non-payment by the State Agency or Healthy Blue. Any action by Provider to collect or attempt to collect from a Medicaid Member any sum owed by Healthy Blue to Provider shall be deemed to be an unconscionable act within the meaning of Kansas Statute§ 50-627 and amendments thereto. Pursuant to Kansas Statute § 40-3227(k)(2), Provider further acknowledges and agrees to continue to provide services to Medicaid Members in the event of Healthy Blue's insolvency for the duration of the period after insolvency for which premium payment has been made by State Agency to Healthy Blue and until the Medicaid Members' discharge from inpatient facilities.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Plan and the applicable State Agency, which applicable terms are incorporated herein by reference. Nothing in this Attachment shall be construed to terminate or reduce the legal responsibility of Healthy Blue to State Agency to ensure that all activities under the Government Contract are carried out. Healthy Blue shall afford Provider access to all necessary training and information to enable Provider to carry out its responsibilities under the Government Contract.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Healthy Blue shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Continuity of Care. Pursuant to Kansas Statute § 40-3230, in the event of the termination of this Agreement for any reason, except termination of this Agreement for cause by Healthy Blue pursuant to subsection (c) below, any Medicaid Member who requires care that is medically necessary and in accordance with the dictates of medical prudence and where the Medicaid Member has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy shall have the right to continue to receive health care services from Provider for a period of up to ninety (90) days from the date of the termination of this Agreement. Provider acknowledges and agrees that Medicaid Members will not be liable to the Provider for any amounts owed for medical care other than any applicable deductibles or copayment amounts as permitted under the Medicaid Program and set forth in the Healthy Blue Provider Manual(s) or in the schedule of benefits for the Medicaid Program.

5.6.1 During the continuity of care provision described in the subsection above, Provider shall continue to provide services in accordance with the terms of this Agreement applicable immediately prior to the termination of this Agreement, and Healthy Blue shall continue to meet all of the obligations of this Agreement, including without limitation, reimbursement in accordance with the PCS.

5.6.2 A Medicaid Member shall not have the right to continuation of care if the termination of this Agreement is for loss of Provider license, or if the termination of this Agreement is due to reasons related to quality of health care services rendered, which may adversely impact the health, safety or welfare of Medicaid Members.

5.6.3 During any such continuation period, Provider agrees to: (i) accept reimbursement from Healthy Blue for all Medicaid Covered Services furnished hereunder shall be in accordance with this Agreement and at the rates set forth in the PCS hereto; and (ii) adhere to Healthy Blue's Policies, including but

not limited to procedures regarding quality assurance requirements referrals, pre-authorization and treatment planning, or pursuant to other Regulatory Requirements.

5.7 Monitoring. Healthy Blue shall monitor the quality of services delivered under this Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by the Medicaid Program or its designee. Provider shall comply with corrective action plans initiated by Healthy Blue. Provider acknowledges that Healthy Blue has the right to monitor Medicaid Covered Services furnished by Provider to Medicaid Members in accordance with Healthy Blue Policies. Provider shall comply with all applicable Healthy Blue Policies and quality requirements as required by Medicaid related to the monitoring of services rendered to Medicaid Members by Provider.

5.8 Permitted Sanctions. In the event Provider fails to meet any performance standard or other Regulatory Requirement of any Agency, or any standard or rule existing under applicable law pertaining to the services provided hereunder, Healthy Blue may assess liquidated damages, sanctions or reductions in payment in an amount equal to any penalty actually assessed by Agency, or under applicable law, against Healthy Blue, due to such performance standard not having been met or due to the breach of such Regulatory Requirement, rule or obligation under this Agreement. Liquidated damages, sanctions or payment reductions for selected failures of performance will be specifically set forth in the provider manual(s).

5.9 Revocation of Delegated Activities. Healthy Blue may revoke delegation of any activities and reporting responsibilities or impose other sanctions if Provider's performance is inadequate. Such revocation shall be consistent with the termination provisions of the applicable delegation addendum or other document.

5.10 Availability and Maintenance of Records. In addition to the Plan Access to and Requests for Provider Records provision of the Agreement, Healthy Blue and Provider recognize that in the event of termination of the Government Contract between Healthy Blue and the State Agency for any of the reasons described in the Government Contract, Healthy Blue shall immediately make available, to the State Agency, or its designated representative, in a usable form, any and all records, whether medical or financial, related to Healthy Blue's and Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to the State Agency. Provider further agrees to maintain clinical and medical records in a manner that is current, detailed and organized; and, which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. In addition, pursuant to Kansas Statute § 40-3203, Provider's record system shall be adequate to provide an accurate documentation of utilization for every Medicaid Member, which clearly identifies, at a minimum, each Medicaid Member by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy, and The Medicaid Program, HHS, CMS, the Office of Inspector General, the State of Kansas Medicaid Fraud Unit, and the State of Kansas Attorney General's Office shall have the right to evaluate through inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement including quality, appropriateness and timeliness of services and such evaluation, when performed, shall be performed with the cooperation of Healthy Blue and Provider. Upon request, Healthy Blue shall assist in such reviews.

5.11 Local Health Departments. If Provider is a local health department, Provider and Healthy Blue shall adhere to the State Agency's and any applicable requirements regarding the coordination of care for Medicaid Members and the reporting of sexually transmitted diseases and tuberculosis to the state health department.

5.12 Community Development and Disability Organizations ("CDDO"). If Provider is a CDDO, Provider and Healthy Blue shall ensure compliance with the requirements of K.A.R. 30-64-27.

5.13 National Provider Identification Number. In addition to being Medicaid certified, Providers shall have a National Provider Identification number (NPI) for participation with Healthy Blue. Providers can obtain their NPIs through the National Plan and Provider Enumerator System located at: https://nppes.cms.hhs.gov/NPPES/Welcome.do. Provider shall submit all NPIs for its physicians and health care providers to Healthy Blue within fifteen (15) business days of receipt and to State Agency on State Agency's T-XXI Provider file. Provider shall submit such information regarding such NPI as reasonably required to permit Healthy Blue to meet its reporting requirement to State Agency. Provider shall not be required to submit NPIs to Healthy Blue if Provider is (i) an individual or organization that furnishes atypical or non-traditional services that are only indirectly related to the provision of health care; or (ii) an individual or business that only bills or receives payment for, but does not furnish, health care services or supplies.

5.14 Authorizations. Provider shall comply with Healthy Blue's preauthorization and authorization processes and procedures applicable to Provider as more fully set forth in the provider manual(s). Healthy Blue shall ensure that any language included in this Attachment or the provider manual(s) concerning prior authorizations (PA) shall be consistent with Regulatory Requirements. Healthy Blue shall ensure that Provider may submit PAs and receive PA determinations in a secure electronic transmission.

5.15 Non-Discrimination Against Participating Providers. Neither Healthy Blue nor Provider shall discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of such provider's license or certification under applicable state law, solely on the basis of such license or certification. This requirement shall not be construed as an "any willing provider" law, and Healthy Blue may limit provider participation to the extent necessary to meet the needs of Medicaid Members or to establish any measures designed to maintain quality and control costs. Neither Healthy Blue nor Provider shall discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

5.16 Prohibited Referrals. In accordance with Regulatory Requirements, Provider is prohibited from referring any Medicaid Members for designated health services to any entity in which Provider, or a member of Provider's immediate family, has a financial relationship.

5.17 Services. In Accordance with State of Kansas State Medicaid Program. The services covered by this Attachment must be in accordance with the State of Kansas State Medicaid Program. Provider shall provide these services to Medicaid Members through the last day that this Attachment is in effect and all final Medicaid benefit determinations are within the sole and exclusive authority of the Medicaid Program or its designee.

5.18 No Refusal to Provide Services. Provider may not refuse to provide Medically Necessary or preventive Covered Services to Medicaid Members for non-medical reasons.

5.19 Provider will Submit Reports. Provider shall submit all reports and clinical information required by Healthy Blue, including EPSDT (if applicable).

5.20 Disputes Will Not Disrupt Care. Healthy Blue and Provider shall be responsible for resolving any disputes that may arise between them, and no dispute shall disrupt or interfere with the provision of services to Medicaid Members.

5.21 Transfers of Medicaid Members. Without otherwise limiting Healthy Blue's rights pursuant to this Agreement, upon Healthy Blue's determination made in good faith and with reasonable belief that a Medicaid Member's health or safety is in jeopardy, Healthy Blue may require that such Medicaid Member be transferred immediately for care to another provider at Healthy Blue's direction, and Provider shall fully cooperate with any such transfer requirement.

5.22 Provider Reporting Requirements. Provider shall comply with the reporting requirements as set forth in K.S.A. 44-1031 and K.S.A. 44-1116.

5.23 Cultural Competency. Provider shall participate with the state's efforts to promote the delivery of services in a culturally competent manner to all Medicaid Members, including those with limited English proficiency and diverse cultural ethnic backgrounds. To that end, Provider agrees to comply with all Healthy Blue Policies designed to ensure that culturally competent services are provided by Healthy Blue both directly and through its health care providers and subcontractors.

5.24 Marketing. Provider shall not engage in any marketing activities to Medicaid Members, for or on behalf of Healthy Blue, except in accordance with Regulatory Requirements. Specifically, Provider shall not distribute any marketing materials to Medicaid Members or in connection with Healthy Blue services unless such materials are first submitted by Provider to Healthy Blue, and Healthy Blue submits such materials to State Agency for approval.

5.25 Conflicts of Interest. Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Provider further covenants that, in the performance of this Agreement, no person having any such known interests shall be employed by Provider.

5.26 Confidentiality. Notwithstanding the Proprietary and Confidentiality section of the Agreement, Healthy Blue operates and communicates with transparency in order to keep providers and KDHE informed of problems or even potential problems in an appropriate manner.

5.27 Incorporation by Reference. This Agreement incorporates by reference all applicable Regulatory Requirements. Any revisions of such Regulatory Requirements shall automatically be incorporated into this Agreement as they become effective. In the event that changes in this Agreement as a result of revisions to applicable Regulatory Requirements materially affect the position of either party, Healthy Blue and Provider agree to negotiate such further amendments as may be necessary to correct any inequities.

5.28 Prescription Drug Monitoring Program. Provider shall comply with Agency policies regarding Prescription Drug Monitoring Program (PDMP) requirements.

5.29 Home and Community Based Services. Provider agrees to maintain compliance with the HCBS settings rule.

ARTICLE VI
TERMINATION

6.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party.

6.2 Termination of Government Contract. If a Government Contract between the applicable State Agency and Healthy Blue terminates, expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further force or effect with respect to the applicable Medicaid Program.

6.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicaid Program are hereby terminated in full and shall have no further force and effect.

ARTICLE VII
GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments. In addition to the Compliance with Provider Manual(s) and Policies, Programs and Procedures provision of the Agreement, Healthy Blue or its designees may modify the provider manual(s) and its Policies. Any and all amendments or changes to the provider manual(s) will be communicated to Provider after State Agency approval and in a manner consistent with the relevant provisions of the Government Contract. Healthy Blue will provide notice to Provider at least thirty (30) days in advance of the effective date of material modifications thereto; however where changes are the result of Regulatory Requirements such advance notice may not be possible.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Notwithstanding, to the extent any provision of the Agreement, this Attachment, or any other exhibit, attachment, or other document referenced herein, is inconsistent with or contrary to any provision of the Government Contract, the relevant provision of the Government Contract shall have priority and control over the matter. In the event of a conflict between the Government Contract and the Agreement, the terms and conditions of the Government Contract shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose to Healthy Blue complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to Healthy Blue at the time of initial contract, upon contract renewal, and/or upon request by Healthy Blue. Provider further agrees to notify Healthy Blue within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.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