Welcome, Introductions & Housekeeping

- Welcome
- Introductions
  - Amerigroup
  - Sunflower Health Plan
  - UnitedHealthcare (UHC)
  - Kansas Department of Health and Environment
  - Kansas Department for Aging and Disability Services
- Housekeeping
  - Break out tables for each MCO – All day
  - Other – Location specific information
Agenda

- Policy Review
- Eligibility & Client Obligation
- Care/Service Coordination vs Targeted Case Management
- Authorizations
- Claim Management
- Grievance & Appeals
- MCO Provider Portals
- Safety Management
- Value Added Benefits
POLICY REVIEW
Rate Increase 7.1.18

Home and Community Based Services (HCBS) rates will increase by 4% for state fiscal year 2019 (dates of service beginning 7-1-2018).

Managed Care Organizations (MCOs) have begun the process of updating claim systems to prepare for the change.

Once the rates are published, providers should prepare to update their claim billed charges based on the new rate for dates of service effective 7.1.18.
KMAP Provider Enrollment and MCO Credentialing

Recent Changes:
January 2018 - Effective 1/1/2018 all new provider enrollments and re-credentialed providers must enroll with KMAP in order to be enrolled/credentialed with an MCO.

Upcoming Changes:
December 2018 – All providers in one of the MCO networks must have an active KMAP Provider ID # in order to remain in the MCO network.

If a provider is in an MCO Network and does not have an active KMAP Provider #, it is strongly recommended that providers submit an enrollment application to KMAP as quickly as possible to ensure compliance well before the due date. Providers can complete their enrollment on KMAP by accessing the following website  https://www.kmap-state-ks.us/Public/Enrollment%20Application.asp. Providers can contact KMAP Provider Enrollment at 1-800-933-6593, option 3, with questions or concerns.

The new KanCare enrollment process only applies to the Medicaid product.

Providers enrolled with other insurance products, such as Medicare or the Marketplace, will still need to submit provider and practitioner demographic changes directly to the payor which they are contracted.
New Policies effective 7.9.18: (See KDADS, HCBS Draft/Final Policies page)
http://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/hcbs-policies

• **Person Centered Service Plan Policy - M2018-041:** Autism (AU), Frail Elderly (FE), Physical Disability (PD), Technology Assisted (TA) and Traumatic Brain Injury (TBI)

• **Person Centered Service Plan Policy - M2018-042:** Intellectual & Developmental Disability (IDD)

**Person-Centered Service Plan (Service Plan)** is a written service plan developed jointly with an individual (and/or the individual’s authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual regarding preferences for the delivery of such services and supports and the providers of the services and supports.

Integrated Service Plan shall now be referred to as the **Person-Centered Service Plan**
Person-Centered Service Plan:

- No Service Plan shall be amended without the participation of the individual.
- All participants of an HCBS waiver shall have a Service Plan completed by their MCO.

Person-Centered Service Plan Meeting:

- At a minimum, an annual (once every 365 calendar days or less), face-to-face meeting.
- Additional meetings may be necessary due to changes in condition.
- Subject to the convenience of the individual and within the contractual timeframe of MCO.
- MCOs shall conduct one face-to-face or telephonic visit after a transition from any alternate setting of care then follow up with quarterly telephone calls, for the first-year post-transition, and face-to-face visits every six months.
Person-Centered Service Plan Meeting Participant Selection & Coordination:
• If an IDD participant does not have a Targeted Case Manager (TCM), the MCO Care Coordinator shall complete the TCM responsibilities.
• Participant, designated legal representative and MCO Care Coordinator are required to participate in the Service Plan Meeting.

Person-Centered Service Plan Meeting Direction:
• Directed by the participant or designated legal representative
• MCO Care Coordinator will provide support in leading the meeting, effectively coordinating the planning process and ensure that all the required components are completed.
• TCM shall provide support in leading the meeting
Person-Centered Service Plan Meeting Forms:

• AU, FE, PD, TA & TBI:
  – Participant Choice
  – Participant Interest Inventory (PII)
  – Rights and Responsibility

• IDD:
  – Participant Choice
  – Person-Centered Support Plan
  – Right and Responsibilities
**Person-Centered Service Plan Policy**

**IDD Behavior Support Plan:** Participant’s chosen TCM or applicable provider, shall complete the Behavior Support Plan in conjunction with impacted providers or external entities included by the provider. Completed behavior support plan shall be shared with the MCO Care Coordinator within 5 business days of approval by the behavior management committee.

**Individual Educational Plan (IEP):** If the participant has an IEP the MCO Care Coordinator shall request a copy.

**Back-up plan development:** Shall be the responsibility of MCOs to complete as part of the Person-Centered Service Plan process.
Documenting Participant Understanding of Service Plan:

- MCO Care Coordinator shall obtain a signature of understanding from the participant or participant’s designated legal representative prior to implementation of the Service Plan.

- Service Plan’s contents shall be clearly documented, including the scope, amount and duration of services established based on participant assessment when a signature is obtained.

- If the participant or participant representative declines signing the Service Plan, MCO Care Coordinator shall document the refusal in writing.
**Documenting Provider Understanding of Service Plan:**
Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Service Plan.

**Obtain Physician/RN statements (FE, PD TA & TBI):** Obtain statement certifying the supervision plan for performance of health maintenance activities supervised and directed using a consumer directed attendant/personal care worker.

**Obtain IDD Specific Physician Statements:** Identify the need for a physician’s statement for Health Maintenance Activities (HMA) or in-home IDD Day Services.

**Confirm appointed designated representatives and paid guardians**
Finalized Person-Centered Service Plan:
MCO Care Coordinator shall supply a final Service Plan to the following:
• Participant or participant’s legal representative
• Each of the participant’s applicable HCBS providers
• IDD - participant’s TCM

Monitoring Implementation of the Person-Centered Service Plan:
• IDD - TCM shall provide ongoing monitoring of progress toward Person-Centered Service Plan goals and coordinate with the MCO Care Coordinator in the event there is a change.
• MCO Care Coordinators shall monitor delivery of the Service Plan, including conducting a six-month face-to-face visit with the participant.

NOTE: KDADS Training will be offered to MCO Care Coordinator, IDD TCMs, KDADS Licensing and State Quality Management Staff.
Final Settings Update

- First major update to Medicaid and CHIP managed care regulations in more than a decade.
- Aligns key rules with those of other health insurance coverage programs and strengthens both the consumer experience and key consumer protections.
- Addresses several sections of Medicaid law, under which states may use federal Medicaid funds to pay for home- and community-based services (HCBS).
- Supports enhanced quality in HCBS programs and adds protections for individuals receiving services.
- Reflects the Centers for Medicare & Medicaid Services’ (CMS) intent to help ensure that individuals receiving services and supports through Medicaid’s HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.
Final Settings Update

• KDADS is working through their plan with CMS related to the Final Settings rule

• States now have until March 17, 2022 to demonstrate compliance with the final rule.
  – For more information, please visit: https://www.medicaid.gov/federal-policy-Guidance/index.html

• KDADS 5.3.18 Request for Designated Provider Contact due 5.15.18.
  – Representative at your organization/agency to receive the provider self-assessment and follow-up communications
  – Designated provider contact form: https://wichitastate.co1.qualtrics.com/jfe/form/SV_eXSUuriMPmtkbhH
Guidance for Post-MFP Transitions Informational Memo, revised 8.18.17 provides the current processes for transitions.

- Qualifications:
  - Current resident in a Nursing Facility, State Hospital (Parsons and KNI), Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IDD), or Psychiatric Residential Treatment Facility (PRTF) with a minimum stay of ninety (90) consecutive days, and
  - Current Medicaid eligibility, and
  - Meet HCBS waiver eligibility for the FE, PD, TBI or I/DD waiver.

- Qualifying transitions receive priority approval by the waiver program manager
- Transition Coordination Services (TCS) or Transitional Funding (TF) out of nursing facilities, or any other formerly MFP-qualified settings, may be provided by the MCO as an “In Lieu” of service per an authorization(s) and Service Plan.
- Transitions from institutional settings shall be into community settings
- Individuals in State Hospitals that wish to transition into the community shall be referred to their MCO of choice by KDADS
HCBS Transition Process

• Once the need for TCS is identified, the Service Coordinator offers a choice of provider to the member. I/DD members: Once choice of TCM provider is communicated to the MCO by the CDDO, the Service Coordinator contacts the TCM provider and discusses the option of providing TCS services for the member, prior to TCM being authorized.

• An approved Transition Evaluation of Need (TEN) Form from KDADS must be in the member’s MCO file prior to requesting TF.

• If additional TCS units are requested by provider beyond the 192 allowable units, provider should submit this request in writing to the Service Coordinator of record and provide the following:
  ✓ Documentation of work that has been completed
  ✓ Noted progress
  ✓ Desired amount of additional units
  ✓ Remaining tasks to be accomplished in order for said transition to occur

• Some MCOs may authorize transition services as value adds.

NOTE: Additional units may be denied if provider does not provide necessary documentation or if it is determined the additional units a unnecessary.
Provider Qualifications

HCBS providers must ensure that employees are appropriately screened and employee records are maintained with supporting documentation as well as proof that validation has been completed for ALL employees.

Qualification requirements vary by waiver and specialty type. Refer to current and approved HCBS waiver for qualification requirements.

Important to continue to be diligent in keeping these in their records.

There is a change coming with the audit process for this information.
ELIGIBILITY & CLIENT OBLIGATION
Member Eligibility and MCO Assignment

• Options
  – KMAP Website
  – MCO Websites
  – EDI transactions (270/271 transactions)
  – KMAP Automated Voice Response System (AVRS)
  – KMAP Provider Services Call Center
  – MCO Provider Services Call Center

• Important items to look for:
  – Does the member have an HCBS Living Arrangement and Benefit Plan?
  – Does the member have a client obligation?
  – Which MCO is the member assigned to?
Eligibility verification can be accessed from the Provider page. The Eligibility tab appears on the menu bar at the top of the page and the Eligibility Verification link is found below the provider information.

Providers should verify eligibility each month.
Eligibility Verification Continued

Beneficiary eligibility can be searched in three different ways.

1. Beneficiary ID
2. SSN and/or Date of Birth
3. Name and Date of Birth

**Dates of Service:** Best practice is to search for a month’s timespan, ie. 5.1.18 – 5.31.18. Users cannot overlap calendar months and dates must be within the last 24 months, counting the current month.

If the member is not KMAP eligible the following message will appear: “The beneficiary is not eligible for the date(s) of service requested.”
Waiver Member Example

Verify **Living Arrangement and Benefit Plan** reflects waiver eligibility. Pay close attention to effective dates.

Applicable **Patient Liability/Client Obligation** is listed here. The MCO assigns the amount per their processes.

Following Clearinghouse updates, KMAP information is updated within 24 hours. MCOs are then updated.
How it all begins:

- KDHE KanCare Clearinghouse determines client obligation as part of the financial eligibility process.
- Generally client obligation is finalized beginning the first day of the month the obligation is effective and no additional changes are to be made to the amount. Occasionally situations warrant a retroactive change be made to the client obligation amount.
- Retroactive increases to the client obligation should not occur. Please report occurrences to the assigned MCO.
- State of KS communicates member client obligation amounts via the monthly 834 eligibility file and daily eligibility change files to the MCO.
- File is received and loaded by the MCO.
Assignment Process:

- MCO assigns an HCBS provider to collect client obligation.
- Assigned based on member choice and/or the HCBS provider with the highest cost of services.
- Members without a change to their services or client obligation amount will have their client obligation assigned to the same HCBS provider as the prior month.
- Every effort will be taken not to split a member’s client obligation between two HCBS providers.
- Client obligation will generally not be assigned to excluded services.
- A member’s plan of care cost must be more than their determined client obligation amount to remain eligible for HCBS services.
Notifications:

- **Member:** Upon any new provider assignment, Amerigroup sends a copy of our client obligation assignment letter to both the member and the assigned provider.
  - If the member has questions about the client obligation amount, please have them call the Clearinghouse at 1.800.792.4884.

- **Provider:** Each week, Amerigroup sends a report electronically to each assigned HCBS provider notifying them of their Amerigroup members with client obligation and the assigned amounts that they are to collect from each member. It is the responsibility of the assigned service provider to collect the client obligation directly from the members.
  - If the provider has no members assigned to them, they will not receive a weekly notice.
  - If the provider has questions about the report, please contact Kristi Daniels at kristi.daniels@amerigroup.com
  - Claim issues related to client obligation can be reported to kscasespec@amerigroup.com
Sample Member and Provider Notification:

<CURRENT_DATE>

SB5B_NAME,
SBAD_ADDR1, SBAD_ADDR2, SBAD_ADDR3,
SBAD_CITY, SBAD_STATE, SBAD_ZIP

Dear SB5B_NAME:

Thank you for being our member.

Home- and Community-Based Services (HCBS) waiver members may have to pay for part of their HCBS in order to keep getting services and continue waiver eligibility. This payment is called client obligation.

The state of Kansas notified us that you have a client obligation. Starting the first day of «month», you’ll have to make monthly payments to your provider, PROV_NAME. Please contact their office at PRAD_PHONE to set up a payment plan.

Your KanCare Clearinghouse eligibility worker will tell you how much your client obligation is. We don’t decide the amount. The state does.

If you have questions about how the state determines your client obligation amount, please call 1-877-434-7579, ext. 50103 (TTY 711) Monday through Friday from 8 a.m. to 5 p.m. Central time.

Sincerely,

Amerigroup Kansas, Inc.

CC: PROVIDER NAME
Sample of Weekly Provider Notification:

<table>
<thead>
<tr>
<th>Amerigroup ID</th>
<th>Medicaid ID</th>
<th>Member name</th>
<th>Waiver</th>
<th>Amount Effective date from state</th>
<th>Current amount</th>
<th>Provider assignment effective date</th>
<th>Provider ID</th>
<th>Provider Name</th>
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<td></td>
<td></td>
<td></td>
<td>FE</td>
<td>2/1/2018</td>
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<td>01-01-2018</td>
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<td>FE</td>
<td>4/1/2018</td>
<td>$2,335.08</td>
<td>05-01-2017</td>
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<td></td>
<td></td>
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<td>FE</td>
<td>1/1/2018</td>
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<td>06-01-2017</td>
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<td></td>
<td></td>
<td>FE</td>
<td>1/1/2018</td>
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<td>06-01-2017</td>
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<td></td>
<td></td>
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<td>FE</td>
<td>1/1/2018</td>
<td>$1,641.20</td>
<td>06-01-2017</td>
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</tr>
</tbody>
</table>
Client Obligation Process: Sunflower

Notifications:

- **Member:** Once eligibility is determined or upon enrollment with Sunflower Health Plan, members are mailed a letter providing general information on client obligation including who assigns the amount, how the member is notified of the amount, how the member will know which provider to pay and how they can change the assigned provider. We include a fact sheet with helpful tips on client obligations. The letter and fact sheet are mailed annually thereafter.
  - Sunflower notifies the member of the assigned provider(s) on the Integrated Service Plan.
  - Sunflower assigns a provider for client obligation for every member in HCBS, even if the amount is $0.
  - If the member has questions about the client obligation letter or fact sheet they are encouraged to contact their Care Manager or to call Sunflower’s customer service at 1-877-644-4623.
  - If the member has questions about the client obligation amount, they are encouraged to call the Clearinghouse at 1.800.792.4884.

- **Provider:** In addition to verifying client obligation assignments via KMAP, providers are able to view their member client obligations on the Sunflower Health Plan Provider Portal. The data is refreshed daily to accurately indicate the member’s obligation amount. Some members may have an amount assigned of $0. Some members may have two providers assigned if the client obligation is more than the cost of care with a single provider. It is the responsibility of the assigned service provider to collect the client obligation directly from the members.
  - The client obligation assignment is listed on the member’s Integrated Service Plan (ISP).
  - If the provider has questions about the client obligation amount, they are encouraged to call the Clearinghouse at 1.800.792.4884.

Client Obligation Process: Sunflower

Sample of letter mailed to Sunflower members.

Letter frequency: upon enrollment and annually.

Dear <<Member’s Name>>,

This letter is to provide you with more information about how to pay your Client Obligation if you have one. Client Obligation is an amount the State determines you need to pay to help cover the cost of your care. It is assigned to you by the State if you have a monthly income that is more than the State allows for protected income.

Please keep a copy of this letter and the attached Client Obligation Fact Sheet with your Integrated Service Plan.

The Fact Sheet will let you know how to tell if you have a Client Obligation. It will tell you how to know who to pay if you have a Client Obligation. It will also let you know who to call if you have questions about Client Obligation.

If you have questions about this letter or the Client Obligation Fact Sheet, or if you need another copy, please call your Sunflower Care Manager. You may also call customer service at 1-877-644-4623 or TDD/TTY 1-888-282-6428 for more information.

Sincerely,

Sunflower Health Plan
Client Obligation Process: Sunflower

Providers are able to view member client obligations via the Sunflower Secure Provider Portal at: https://provider.sunflowerhealthplan.com
Notifications:

- **Member:** Each month, UHC sends a letter to members notifying them of the amount of client obligation as well as the description of the service it is assigned to & the corresponding HCBS provider who will be collecting that amount.
  - If the member has questions about the client obligation amount, please have them call the Clearinghouse at 1.800.792.4884.

- **Provider:** Each month, UHC sends a report electronically to each assigned HCBS provider notifying them of their UHC members with client obligation, the assigned amounts that they are to collect from each member and the service descriptions & codes that the client obligation amounts are assigned to. It is the responsibility of the assigned service provider to collect the client obligation directly from the members.
  - After 3 unsuccessful attempts to deliver the report electronically, it is sent via post office to the providers physical address.
  - If the provider has no members assigned to them, they will not receive a monthly notice.
  - If the provider has questions about the report, please contact Samantha Torrez @ samantha_l_torrez@uhc.com or 913.333.4018.
  - Claim issues related to client obligation can be reported to the HCBS Provider Advocate.
Sample Member Notification:

UnitedHealthcare Community Plan
10895 Grandview, Suite 200 Overland Park, KS 66210

[Date]

[Member Address]

Dear [Member Name],

Thank you for choosing UnitedHealthcare Community Plan of Kansas. We value you as a customer and are pleased to be serving you as part of KanCare.

You are receiving this letter because the State has notified UnitedHealthcare Community Plan of Kansas your monthly client obligation amount, also known as patient liability, has been changed. Please send your payment to the provider listed or call your care coordinator if you have questions:

Provider:
Amount:
Effective Date:
Affected Service(s):

The amount of the client obligation is decided by the Kansas Clearinghouse and may change monthly. If you have questions about this amount, please call the Clearinghouse at 1-800-792-4884.

We are honored to have you as a member. We want to help you every step of the way. If you have questions, please call 1-877-542-9238.

Thank you,

UnitedHealthcare Community Plan of Kansas
HCBS Client Obligation Process - UnitedHealthcare

Sample Provider Notification:

UHC recommends providers rely on the KMAP website and monthly client obligation notices to verify amounts and assignment.
CARE/SERVICE COORDINATION VS TARGETED CASE MANAGEMENT
<table>
<thead>
<tr>
<th>TARGETED CASE MANAGEMENT</th>
<th>CARE/SERVICE COORDINATION</th>
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</thead>
<tbody>
<tr>
<td><strong><em>limited to 240 units per calendar year without prior authorization</em></strong></td>
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</tr>
<tr>
<td><strong>Description:</strong> Consists of services aimed specifically at special groups of enrollees such as those with Intellectual/developmental disabilities or chronic mental illness. The definition includes four components as identified by CMS. The following list is not exhaustive but provides typical examples of targeted case management activities.</td>
<td><strong>Description:</strong> Consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. This includes primary care case management which cannot be provided by a targeted case manager.</td>
</tr>
<tr>
<td><strong>Assessment:</strong></td>
<td></td>
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<tr>
<td>- Participate in the BASIS assessment.</td>
<td>Completes a comprehensive health –based needs assessment.:</td>
</tr>
<tr>
<td>- Complete Statewide Needs Assessment</td>
<td>Care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care and service plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.</td>
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<tr>
<td>- Gather information from other sources as necessary to complete the assessment.</td>
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<tr>
<td>- Take consumer history</td>
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<tr>
<td>- Identify the individual’s needs and complete the assessment instrument and related documentation.</td>
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</tbody>
</table>
### Targeted Case Management Care/Service Coordination

<table>
<thead>
<tr>
<th>Develop Person-Centered Support Plan:</th>
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</thead>
<tbody>
<tr>
<td>- Develop/update Person Centered Support Plan. Working with individual and others to develop goals and identify course of action to respond to the assessed needs. Provides plan to MCO service coordinator of record.</td>
</tr>
<tr>
<td>- Develop/Update Behavior Support Plan - Participate in development of Individual Education Plan (not just attendance at meetings) - Discuss service options, needs and preferences</td>
</tr>
<tr>
<td>- Provide input into the Person-Centered Service Plan</td>
</tr>
<tr>
<td>- Includes activities such as ensure active participation of the eligible individual and work with the individual (or the individual’s authorized health care decision maker)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Develop Person-Centered Service Plan:</th>
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<tbody>
<tr>
<td>- Develop service plan, including physical &amp; behavioral, based on the needs assessment and with input of the individual, family members, guardians or other persons providing support</td>
</tr>
<tr>
<td>- Coordinate and approve services and supports to meet an individual’s needs for physical health, behavioral health, social, educational, medical and long-term supports and services needs</td>
</tr>
<tr>
<td>- Implement Person-Centered Support Plan and authorize services</td>
</tr>
<tr>
<td>- Manage through the use of quality metrics, assessment and survey results and utilization reviews to monitor and evaluate impact of interventions.</td>
</tr>
<tr>
<td>- Update Person-Centered Service Plan with TCM based on Service Plan, BSP and changing needs</td>
</tr>
</tbody>
</table>

### CARE/SERVICE COORDINATION VS TCM
## CARE/SERVICE COORDINATION VS TCM

<table>
<thead>
<tr>
<th>TARGETED CASE MANAGEMENT</th>
<th>CARE/SERVICE COORDINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral &amp; Related-Activities:</strong></td>
<td><strong>Additional Activities:</strong></td>
</tr>
<tr>
<td>- Activities that help link the individual with medical, social or educational providers</td>
<td>- Assist in scheduling referrals and creating/promoting linkages to other agencies, services, and supports, including to behavioral health services</td>
</tr>
<tr>
<td>- Referral to resources and other programs to assist with direct services and applications</td>
<td>- Locate resources beyond scope of services covered by Medicaid or through the HCBS services, which may be available from different sources</td>
</tr>
<tr>
<td>- Referral to link an individual to services including medical, social, or educational providers.</td>
<td>- Engage patients in self-care regarding chronic conditions - Provide information and resources with the TCM</td>
</tr>
<tr>
<td>- Seek informal supports to provide services and supports to an individual - Report ANE or suspected ANE &amp; make referrals as necessary</td>
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</tbody>
</table>
### TARGETED CASE MANAGEMENT

**Monitoring & Follow-up:**
- Monitoring includes identifying changes in the needs and status of the individual
- Activities and contacts necessary to ensure the services plan is implemented and adequately addresses the individual’s needs, and which may be with the individual, family members, providers, or other entities
- Identify changes in needs and status. Notify and provide information to the MCO Care Coordinator

### CARE/SERVICE COORDINATION

**Primary Care Case Management:**
- Coordinate and collaborate with other providers to monitor individual’s health status, medical conditions, medications and side effects
- Monitor emergency and inpatient admissions to ensure appropriate transitions in care are coordinated and timely
- Monitor individual’s health status, medical conditions, medications and side effects if necessary
- Identify individuals that are high risk for environmental factors or medical and those with complex health care or behavioral health needs
AUTHORIZATIONS
All HCBS services require prior authorization.

Authorization must be obtained before starting services.

Authorizations do not guarantee payment.

Authorizations do not supersede plan policy and procedure requirements, nor does it guarantee member eligibility.
CLAIM MANAGEMENT
Each MCO is allowed to set timely filing requirements as part of each individual contract with providers. Review individual provider contracts for timely filing requirements.

- **New day claims**
  - Generally, the timely filing requirement for new day claims is 180 days* from the date of service
- **Corrected claims**
  - Timely filing requirement is 365 days* from the paid date
- **Claims impacted by Retro-eligibility**
  - Timely filing requirements begin on the date the member was deemed eligible by the state. A provider has 180 days* from the date the member was determined eligible by the State to file an their initial claim

*Providers must check their individual contract for each MCO for provider specific timely filing requirements.*
Tips for Filing Claims

• If submitting a paper claim a provider must use a red and white claim form. Hand written claims and photo copied claims are not allowed
• Claim must be submitted with the member’s Medicaid ID # which can be found on their ID card
• The name submitted on the claim must match the name on their ID card
• Ensure the address noted in box 33a matches the address on file with the state, if applicable, and with the MCO.
• Ensure claims are submitted with the appropriate modifier on initial submission to avoid unnecessary claim corrections.
• MCOs have 30 days to process and provide a response on a claim. Submitting the same claim multiple times will only result in duplicate claim denials. If a provider is unsure of a claim status, utilize the MCO self service tools or call Provider Services prior to submitting additional claims.
AuthentiCare/EVV Requirements

**EVV Requirements:**
Direct service workers (DSW) of (KDADS-HCBS) (FE, I/DD, PD, TBI, TA) and Money Follows the Person (MFP) (FE, I/DD, PD and TBI) programs are required to utilize the AuthentiCare KS EVV system to document time worked and activities relating to service delivery. The utilization of the EVV system is necessary to meet documentation requirements in order to support claims submitted for reimbursement of services rendered.

**Exemptions to EVV:**
- Effective April 1, 2017, the following codes are exempt from EVV - FE S0315 - Telehealth Installation, FE S0317 - Daily Telehealth, FE, PD, and TBI S5185 - Medication Reminder
- Value Added HCBS Benefits
- In lieu of

**Accommodations:**
Use of the EVV system is allowed for the following situation(s) and must be documented in AuthentiCare KS system:
- The consumer or worker who is deaf or hard of hearing and requires the use of TTY equipment or suitable alternative (i.e. mobile application) and the accommodation is not readily available.
- There is not an authorized plan of care entered in the AuthentiCare KS system. In such cases, an accommodation to the use of EVV is allowed if the consumer/provider receives written service authorization from MCO. The delay in authorization from MCO must be notated in the AuthentiCare KS system. Documentation to support the lack of authorization must be available to KDADS upon request.
AuthentiCare/EVV Requirements

**Accommodations contd.**
- AuthentiCare KS system failures validated with the vendor (First Data).
- An EVV accommodation for lack or loss of equipment, equipment failure or user error is allowed as an accommodation once monthly. It is the responsibility of the employer (consumer) to have a backup plan for making the necessary equipment/tool available to the worker to comply with required documentation of time and attendance.
- An emergency medical or personal crisis requiring immediate response to the situation resulting in the inability to use the EVV to document time and attendance.

**Accessing the formal request:** Any accommodation to the use of the EVV system outside of the situations indicated above will require a formal written request. A formal request for accommodation to the use of the EVV system must be submitted via the Request or Accommodation to use of KS AuthentiCare KS EVV form. The form must be submitted to the KDADS HCBS General Utility Upload: http://www.kdads.ks.gov/commissions/csp/hcbs-file-utility

Provider Remittance Advices (PRA), also known as Explanation of Payment (EOP), is the primary source for providers to see how a claim was processed.

Claims submitted to KMAP for routing to the MCOs will get Front End Billing EOP’s if KMAP was unable to pass the claim along to the MCO for processing.

It is critical providers review and post payments and denials noted on PRA’s/EOP timely in order to ensure corrected claims or reconsiderations are submitted within required timelines. Additionally it allows you to quickly resolve any outstanding items and remove dollars from outstanding accounts receivable reports.
All 3 MCOs have self service tools on their websites, Provider Services Call Centers and Provider Relations staff to assist with claims questions. When reaching out for assistance please make sure you have the following information:

• The MCO claim number
• The member’s Medicaid ID #
• The date of service on the claim
• Total billed charges
• The Tax ID # or NPI for the provider
• Provider Contact Information

If working with one of our call centers or Provider Relations staff, please make sure you note in your file the name of the person you spoke with and the date and time of the call.
A corrected claim would be needed if the provider determines there was an error on the original claim either by their own internal review or based on how the MCO processed their claim. The following items must be included on the corrected claim or it will be denied as a duplicate claim:

- Indicate a 7 to replace the claim or 8 to void the claim in its entirety as the frequency/resubmission code.
- Include the original MCO claim number in the Original Reference Number field.
- Submit the corrected claim **within 365 days** of the original paid date, although we strongly recommend submitting corrected claims as quickly as possible.
- Check with the MCO to learn what options are available for submitting corrected claims, i.e. Electronically, paper, etc.
Recoupments are generated when an overpayment is identified for a provider and the MCO is working to recover the amount owed.

Overpayments can be identified in a number of ways:
- Corrected or adjusted claims identified by a provider
- Post pay claim reviews conducted by the MCO.

Common reasons for post pay review:
- Coordination of Benefits/Third Party Liability
- Patient Liability
- Client Obligation
- Duplicate claim payment
- Overlapping Dates of Service
- Retro-active rate changes
Below are the two options for providers to notify Amerigroup of an overpayment of claims. Both of these forms are found under the “Forms” section of our website at providers.amerigroup.com/ks and both should be mailed to the applicable addresses:

**Refund Notification Form** is used when the provider wants to issue a refund check immediately. This form should be filled out and mailed to the below address, along with the refund check.

Amerigroup  
P.O. Box 933657  
Atlanta, GA 31193-3657

**Recoupment Notification Form** is used when the provider wants to alert us to an overpayment, and initiate the recovery process. This form should be filled out and mailed or faxed to the below address:

Attn: Cost Containment – Disputes  
Amerigroup  
P.O. Box 933657  
Atlanta, GA 31193-3657
Refund MCO Overpayment: Sunflower

Providers can report “unsolicited” overpayments or improper payments to Sunflower Health Plan.

• Providers have 60 days from the date of notification to refund “unsolicited” overpayments or to establish a payment plan (when available) before claims are reprocessed.

• Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:

  Sunflower Health Plan
  P.O. Box 955889
  St. Louis, MO 63195-5889
Providers can submit a letter authorizing recoupment or application of an enclosed check with the following supporting documentation. The downloadable spreadsheet is posted on our website.

- Claim number
- Service line number
- Member Name
- Medicaid ID
- Patient Control Number (provider’s unique identifier)
- Date of Service
- Procedure
- Billed Amount
- Paid Amount
- Paid Date
- Amount to recoup* required
- Reason for recoupment* required

- Sunflower cannot recoup claims or coordinate benefits if all other payer’s EOBs are not attached.
- Providers may utilize the Secure Provider Portal and within the Claims tab may select to Void/Recoup a Claim.
- Refer to the provider bulletin on Coordination of Benefits & Third Party Liability https://www.sunflowerhealthplan.com/newsroom/shpbn-2015-037.html
Unsolicited Refund process

Providers, who wish to refund an overpayment on any UnitedHealthcare Community and State account for the KanCare program, may do so by submitting a check to the following address:

United HealthCare, PO Box 5230, Kingston NY 12401

To ensure the refund is accurately credited, follow the steps outlined here:

Refunds should be accompanied with the information found here:
http://www.uhccommunityplan.com/health-professionals/ks/provider/forms.html

Do not use this process if UHC has already identified the overpayment and sent an overpayment notification letter.
GRIEVANCE & APPEALS
Reconsiderations can be submitted by a provider when they believe a claim was processed incorrectly by the MCO. Although each MCO process may vary slightly the general guidance is the same.

Effective with claims processing date 5/1/17 and after, reconsiderations must be submitted within 120 calendar days from the date of the remittance advice (RA), explanation of payment (EOP), or denial notice. Submission of a Reconsideration is optional and does not replace the Appeal Process.

- Providers are strongly encouraged to submit a reconsideration as soon as they determine the claim needs to be reviewed by the MCO.
- Submit the reconsideration to the MCO making note of the specific error made on the claim and explain what the correct outcome should be on the claim.
- Provide any documentation or additional supporting information for the desired outcome for the claim.
- Provide all data elements required on the MCO form or electronic reconsideration request.
Claim Reconsideration

- Once an MCO receives the Reconsideration, it will review the payment denial and issue a Reconsideration resolution notice. The MCOs are not required to resolve Reconsiderations within a defined period of time.
- Providers will receive a notice of reconsideration determination either through a provider remittance advice or a notification letter.
- Providers may terminate the Reconsideration process and file an Appeal within 60 calendar days of the date of the RA, EOP, or denial notice – or no later than 60 calendar days from the date of the Reconsideration resolution notice. An additional three calendar days from the RA, EOP, or denial notice date are added to the submission timeframe.

Note: Completion of the Reconsideration process is not required prior to requesting an Appeal. Providers have the opportunity to submit an Appeal to the MCO instead of submitting a Reconsideration or after receipt of the Reconsideration resolution notice. Reference KMAP General Bulletin #18039.
Claim Reconsideration: Amerigroup

Verbal submissions may be submitted by calling Provider Services at 1-800-454-3730.

or

Amerigroup can receive reconsiderations via the Availity Payment Appeal Tool at www.availity.com

or

Providers may mail their written reconsideration or reconsideration forms to the below address:

    Payment Appeal Unit
    Amerigroup Kansas, Inc.
    P.O. Box 61599
    Virginia Beach, VA 23466-1599

Reconsideration Form:
https://providers.amerigrouop.com/ProviderDocuments/KSKS_CAID_ReimbursementReconsiderationForm.pdf
Claim Reconsideration: Sunflower

Reconsiderations may be submitted via:

• **Phone:** 1-877-644-4623

• **Email via Secure Provider Portal:**
  – Log into the secure web portal and click “Create Message”,
  – In the subject line drop down box choose “Reconsideration”.
  – In the note section describe the reasoning for the Reconsideration request and the appropriate claim number.
  – Then click send.

• **Mail**
  Sunflower Health Plan P.O. Box 4070 Farmington, MO 63640-3833
Claim Reconsideration: UnitedHealthcare

Reconsiderations can be submitted through various options:

- **Electronically:** Using the claimsLINK Self-Service Tool at www.uhcprovider.com
- **By phone:** 877-542-9235
- **By mail:** UnitedHealthcare
  PO Box 31350
  Salt Lake City, UT 84131-0350
Appeals

If a provider disagrees with an MCO action or a reconsideration determination the next step would be to initiate the formal appeal process

- Providers must submit the Appeal within 60 calendar days of the date on the remittance advice (RA), explanation of payment (EOP) or denial notice.

- Providers may terminate the Reconsideration process and submit an Appeal within 60 calendar days of the date of the RA, EOP, or denial notice. Providers who choose to terminate the Reconsideration process, but do not submit an Appeal within 60 calendar days, must wait to receive the Reconsideration resolution notice from the MCO before submitting an Appeal. An additional three calendar days from the RA, EOP, or denial notice date are added to the submission timeframe.

- All provider appeals must be submitted in writing. The written request must specifically indicate an appeal is being requested
Appeals

- Providers will receive a written acknowledgment of the appeal within 10 calendar days of the appeal receipt, unless the appeal is resolved prior to this timeframe.

- Once an MCO receives the Appeal, it will review the payment denial and issue an Appeal resolution notice. The MCOs are required to resolve 98% of Appeals within 30 calendar days of receipt and 100% within 60 calendar days of receipt.

- The provider will receive a written notice from the MCO indicating the outcome of the appeal.

- Providers must complete the MCOs Appeal process prior to requesting a State Fair Hearing.

Reference KMAP General Bulletin #18040
Providers may mail written appeals or appeals forms to the below address:

Payment Appeal Unit
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Appeal Form
https://providers.amerigroup.com/ProviderDocuments/KSKS_ClaimPaymentAppealForm.pdf

Providers may submit appeals via the Availity Payment Appeal Tool at www.availity.com:

• When inquiring on the status of a claim, a dispute selection box will display. Once this box is clicked, a Web form will display for the provider to complete and submit. The provider will receive immediate acknowledgement of the submission once the form is fully completed. Supporting documentation can be uploaded by the use of the attachment feature on the Web dispute form and will attach to the form when submitted.

Side note- If the provider chooses to forgo the reconsideration process, the provider must specifically note, “I would like to bypass the reconsideration process” either in the comments section on Availity or stipulate in the written appeal or the appeal form
Appeals: Sunflower

Providers may only file an appeal in writing and must include the Provider Reconsideration & Appeal Form and send it to:

Sunflower Health Plan
P.O. Box 4070
Farmington, MO 63640-3833

If the request does not specifically indicate an appeal is being requested, it will process as a reconsideration.
Appeals: UnitedHealthcare

Appeals can also be submitted electronically using the claimsLINK Self-Service application.

Appeals can be submitted in writing and mailed to UHC at the following address:

UnitedHealthcare
Attention: Formal Grievances and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

If the request does not specifically indicate an appeal is being requested, it will process as a reconsideration.
All providers have the right to request an administrative fair hearing, also known as a state fair hearing, following receipt of the negative outcome of their claims appeal or clinical appeal.

• To request a state fair hearing, the provider must send a written request to:
  
  Office of Administrative Hearings
  1020 South Kansas Avenue
  Topeka, KS 66612-1327

• The request must specifically request a fair hearing. The request should describe the decision appealed and the specific reasons for the appeal.

• The request must be received by that office within 120 calendar days of the date of the negative action. Providers are given 3 additional calendar days to allow for mailing the state fair hearing request

Providers must complete the MCO appeals process prior to filing for a state fair hearing.
MCO PROVIDER PORTALS
MCO Provider Portal: Amerigroup

How Can We Help You?

Amerigroup & You

Providing care for those who need it most requires a team effort and there’s no more critical person on this team than you the provider. Our challenge is to find ways to help you use your resources as efficiently and productively as possible. And that begins by listening to the problems you encounter and the ideas you have to make the system work better. Together we can find the real solutions that can make a difference in people’s lives.

Join Our Network

Interested in joining the Amerigroup network?

Get Started

The States We Serve

Amerigroup currently operates in 12 states and is growing!

Florida  Louisiana  New Mexico
Georgia  Maryland  Tennessee
Iowa  Nevada  Texas
Kansas  New Jersey  Washington

Login

Are you a new user? Register >
MCO Provider Portal: Amerigroup

providers.amerigroup.com

News & Announcements

Please help us improve our provider website by taking this brief survey.

October updates

Budget shortfall payment reduction - second clarification

Provider Resources & Documents

Provider Self-Service

Do more online by registering for Provider Self-Service

Through Provider Self-Service, you can:

- File and check the status of medical claims
- Verify eligibility
- Request precertification
- And much more!

To log in, use your Availity ID and password. If you need an Availity ID, visit...
MCO Provider Portal: Sunflower

The Tools You Need Now!
Our site has been designed to help you get your job done.

Login
- User Name (Email)
- Password

Need To Create An Account?
Registration is fast and simple, give it a try.

Quick Eligibility Check
- Member ID or Last Name: 123456789 or Smith
- Birthday: mm/dd/yyyy
- Check Eligibility

Recent Claims
- Status: 
- Received Date: 02/10/2018
- Member Name: 
- Claim No.: 

Welcome
- Add a TIN to My ACCOUNT
- Spend Down
- Reports
- Patient Analytics
- Provider Analytics

Recent Activity
- Date
- Activity
Sunflower Provider Portal – Benefits
  – View Member Eligibility
  – View Patients and Patient Lists
  – Review Authorizations
  – Create and Submit Claims
  – Secure Messaging
  – Submit referrals for Care Management / Behavioral Health services with Sunflower
With our provider portal, everything you need is in one place. Providers are able to quickly find information and Link self-service tools. **UHCprovider.com** replaces UnitedHealthcareOnline.com

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**Hello!**

Welcome to your new home for the latest news, policy information and access to Link self-service tools for care providers.

- Claims and Payments
- Eligibility and Benefits
- Policies and Protocols
- Prior Authorization and Notification
Tools and resources to help manage the submission of claims and receipt of payments. The primary UHC claims resource, the claimsLink application, is available on your Link dashboard.

- View claims information for multiple UHC plans
- Access letters, remittance advice documents and reimbursement policies
- Submit additional information requested on pended claims
- Flag claims for future viewing
- Submit claim reconsideration and corrected claim requests
- Receive instant printable confirmation for your submissions

Verify member eligibility, determine benefits, view care plans and more. The eligibilityLink app is the primary online source for eligibility and benefit information.

Tools and resources to help manage prior authorizations and notifications. Prior Authorization and Notification application (PAAN) is available on your Link dashboard.
SAFETY MANAGEMENT
Safety Tips & Reminders

• The MCO Care Coordinators were recently asked for feedback on what they are seeing and messaging they want us to share.
• As caregivers and care coordinators it is our responsibility to take steps to identify safety issues for our members and take steps to prevent and/or otherwise minimize the risks.
• Our partnership and good communication is key to ensuring safety issues are identified and managed appropriately.
• You are our eyes and ears – SEE SOMETHING; SAY SOMETHING
  – Please notify the Care Coordinator if there are any concerns relative to member’s well-being
  – Make sure there is compliance with back-up plans and if there are any issues notify the Care Coordinator
Safety Tips & Reminders

- **Know your surroundings** and always have an exit plan
- Keep your **cell phone available and charged** for emergency calls
- Be aware of **unclean areas**
- If **animals** live in the house:
  - There needs to be a scheduled cleaning
  - Review with member flea/tick protection measures
- Check member for **bug bites** on body
  - If bug bites found are of concern let Care Coordinator and PCP know
- **Electrical outlets** should be free from multiple plug-ins which can cause fire
- **Food Poisoning Risk**: Make sure food is not outdated, old or moldy. Remove as necessary
- **Evacuation Plan** for various risks (fire, tornado, flood)
  - Is there an evacuation plan?
  - Is Caregiver aware of plan?
- **Ambulation/Fall Risk**:
  - Does member need DME for ambulation?
  - Are they falling frequently or at risk for falls
    - Do their shoes fit properly?
    - Does the member hold onto furniture?
    - Are there clear paths for ambulation?
  - Bathroom safety – Does the member need a shower chair, toilet riser, hand held commode?
Safety Tips & Reminders

• **Medication Management**
  – Check to see if member knows medications
  – Monitor for noncompliance
  – Problem Identification – multiple meds and hoarding; how many MD’s is member getting meds from
  – Family Involvement: are member’s meds coming up short?
  – NOTE: Care Coordinators should be contacted if there is a need for a Medication review from HHA nurse

• **Abuse**
  – Remember Care Coordinators are not there and cannot see,
  – Notify Care Coordinator if there are concerns

• **Scam Exposure**
  – Be alert to any scam activity such as sweepstakes and “bill collectors”

• **Electrical Outages:**
  – Plan for electrical outage
  – If member is on O2 – should have portable O2 tanks and caregiver should know where this is located
Adverse Incident Reporting

Adverse Incident Reporting & Management:
Reference Policy 2017-110, eff. 9.1.17 for complete details.

- All adverse incidents shall be reported no later than 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web based Adverse Incident Reporting (AIR) system.

  **Link to Adverse Incident Reporting System:**

- Incidents shall be classified as adverse incidents when the event or incident brings harm, or creates the potential for harm to any individual being served by a KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, Behavioral Health Services programs.

- All reports regarding abuse, neglect, exploitation, and fiduciary abuse shall be to the Department of Children and Families (DCF).

- Once the DCF reports are automatically uploaded in the AIR System, duplicate reports to the KDADS Adverse Incident Reporting (AIR) System shall not be required. Duplicate reports will therefore be required until KDADS provides notice that the DCF upload process is functional.

- Reporting of all other adverse incidents shall be made via the Adverse Incident Reporting (AIR) system.
VALUE ADDED BENEFITS
Value Added Benefits: Amerigroup

Healthy Rewards
Members can use points to buy fun and healthy items from our rewards catalog. Points are earned when members get: Well-child checkups, Mammograms, Cervical cancer screenings, Flu shots, Diabetic screenings, Refills of medication used to treat schizophrenia, Refills of medication used to treat asthma, Step-Up Challenge

Maternal Health Healthy Rewards
Members get $20 loaded to a debit card when they go to each of your prenatal and postpartum visits on time. Cards can only be used in stores to purchase from an approved list of items

Weight Watchers Vouchers
Members can receive one Weight Watchers voucher good for initiation fee and 4 weeks of classes.

Boys and Girls Club Membership
Free yearly membership at participating locations, for members ages 5-18
Value Added Benefits: Amerigroup

Adult Preventative Dental Care
2 cleanings annually
Scaling and polishing procedures to remove coronal plaque, calculus and stains

Non-emergent Transportation for Members to Community Events
Transportation for members to authorized non-provider, community events for various health and wellness activities.

Non-emergent Transportation for Caregivers
Transportation for member's caregivers to Medicaid covered appointments

Healthy Families Program
Telephonic whole-family education program for families with a child between the ages of 7–13 who are overweight, obese, or at risk of becoming overweight or obese.
Value Added Benefits: Amerigroup

Respite Care for FE Waivers  HCPC S5151
Caregivers of members in the FE waivers can receive up to 56 hours of respite services.

Respite Care HCPC S5151 & Personal Assistant HCPC S9125 for MR-DD Waivers
Caregivers of members in the MR/DD waivers can receive additional hours of respite and personal assistant services above what Medicaid covers.

Safelink
Safelink provides a free smartphone for members who qualify for a Federal Lifeline program.

Smoking Cessation
Holistic smoking cessation program providing coaching and support services as well as helping members understand the full range of nicotine replacement therapy products available through KanCare.
Pest Control
Eligible members can receive up to four treatments of free in-home pest control.

Adult Podiatry
Adult members may receive four podiatry visits per year, with diagnosis of diabetic neuropathy and/or peripheral vascular disease

Grief Counseling
Grief counseling and access to grief support groups for members who need help during times of significant loss

Air Purifier with Permanent Filter
Free air purifier with a permanent filter for members diagnosed with allergies.

Mail Order Over the Counter Pharmacy
$10 member monthly allowance towards the purchase of OTC products via a secure website.
<table>
<thead>
<tr>
<th><strong>2018 Value Added Benefits</strong></th>
<th><strong>2018 Value Added Benefit Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour Nurse Advice Line</td>
<td>No matter what time or day our nurses are here to help members with any health related problem</td>
</tr>
<tr>
<td>Community Programs for Children</td>
<td>Free services and events to promote healthy lifestyles for kids, such as membership fees to Boys &amp; Girls Clubs and the Adopt-a-School Program</td>
</tr>
<tr>
<td>Choose Health</td>
<td>Program to help members with chronic health conditions. This program helps members determine how emotions can impact their condition (i.e. stress, poor sleep, and change in appetite). As a part of the program, participants are assigned a Health Coach who works with the entire health care team to ensure members have everything they need to feel their best.</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>The Community Health Services Department is a non-clinical, “boots-on-the ground” approach to member outreach. The Community Health Services Reps live and work in the areas that they serve, and provide a formalized range of activities such as: member outreach, community education, informal counseling, social support, and advocacy. Their focus is community health with an emphasis on social determinants of health, health equity and health disparities.</td>
</tr>
<tr>
<td>Dental</td>
<td>Two dental visits (cleanings, screenings) for adults 21 and older every year. Children receive regular benefits on most dental services. We provide practice visits to dentists for members with developmental disabilities and children on the autism waiver to help them become more comfortable with dental preventative care visits</td>
</tr>
<tr>
<td>Dentures</td>
<td>May be covered for members on the Frail &amp; Elderly (FE) waiver. Eligibility is based on medical necessity.</td>
</tr>
<tr>
<td>Farmers Market Voucher</td>
<td>Members can receive $10 produce vouchers at special events with participating Farmers Markets</td>
</tr>
</tbody>
</table>
# Value Added Benefits:
## Sunflower

<table>
<thead>
<tr>
<th>2018 Value Added Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Free Safelink Smartphone</strong></td>
<td>Free smartphone through SafeLink®, which provides up to 350 free minutes of service per month for members who qualify. This includes unlimited texting and 1GB of data per month for the first three months, then 500MB per month. Members will be able to have telephone access to their KanCare providers and unlimited calling to Sunflower.</td>
</tr>
<tr>
<td><strong>Healthy Rewards Program</strong></td>
<td>Members can earn $10-$50 in rewards for preventative doctors' visits with our CentAccount program. Rewards can be used for hundreds of items like groceries, baby formula, over the counter medications, and more from participating retail stores, like CVS, Dollar General and Walmart.</td>
</tr>
<tr>
<td><strong>Healthy Solutions for Life</strong></td>
<td>Program to help with chronic conditions and weight management with unlimited coaching.</td>
</tr>
<tr>
<td><strong>Hospital Companionship</strong></td>
<td>Up to 16 hours of hospital companionship for members on the FE and IDD waivers</td>
</tr>
<tr>
<td><strong>In-home Tele-health</strong></td>
<td>Available for adults with chronic conditions</td>
</tr>
<tr>
<td><strong>Respite Care</strong></td>
<td>Sunflower Health Plan offers up to 16 hours of respite care for IDD wait list members, FE waiver members and children adopted from Foster Care.</td>
</tr>
<tr>
<td><strong>Start Smart for Your Baby</strong></td>
<td>Start Smart for Your Baby® program for pregnant members, babies and families. Start Smart for Your Baby offers nursing support, education and helpful gifts. There is no cost to member.</td>
</tr>
<tr>
<td></td>
<td>• In-home help with healthcare and social service benefits</td>
</tr>
<tr>
<td></td>
<td>• Special texting program for Start Smart participants</td>
</tr>
<tr>
<td></td>
<td>• Community baby showers for pregnant members. Diapers and other gifts are included in these events.</td>
</tr>
<tr>
<td></td>
<td>• Birthday programs for children</td>
</tr>
<tr>
<td></td>
<td>• Sunflower covers mosquito repellant spray for pregnant members</td>
</tr>
</tbody>
</table>
## Value Added Benefits: Sunflower

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<thead>
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</tr>
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<tbody>
<tr>
<td>Sunny’s Kids Club</td>
<td>Sunny’s Kids Club will mail a new book four times a year children (parents) who are enrolled in this program. Sign up is available on our website.</td>
</tr>
<tr>
<td>Targeted Disease Management</td>
<td>Available for members with conditions such as asthma, congestive heart failure, COPD, diabetes, HIV/AIDS and Sickle Cell.</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Members can participate in a smoking cessation program offered through Sunflower’s Healthy Solutions for Life program. (Nicotine replacement therapy is a regular Medicaid benefit when prescribed by the doctor.)</td>
</tr>
<tr>
<td>My Strength Online Program</td>
<td>MyStrength online program offers eLearning to help members overcome depression and anxiety. This online program includes simple tools, weekly exercises, mood trackers and daily inspirational quotes and videos. The program can be used on its own or with other care.</td>
</tr>
<tr>
<td>Medication Review</td>
<td>A Comprehensive Medication Review with a local pharmacist is available to eligible members. The review includes a 30 minute Face-to-Face consultation with a local pharmacist.</td>
</tr>
</tbody>
</table>
### Value Added Benefits for All Members

<table>
<thead>
<tr>
<th>Value-Added Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Rewards Program</td>
<td>Members will be invited to earn a reloadable debit card rewards for specific health related activities. Debit cards mailed when activity is completed as determined using claims data.</td>
</tr>
<tr>
<td>myUHC.com</td>
<td>Online tools for members or those responsible for managing their health. Access to health history, tips for working with their doctor, tracking doctor visits, a live “Nurse Chat” option and much more.</td>
</tr>
</tbody>
</table>

### All Adults

<table>
<thead>
<tr>
<th>Value-Added Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Dental Exam</td>
<td>Any member 21 and older can visit a participating dental provider two times a year for a screening, plus one X-ray and cleaning annually.</td>
</tr>
<tr>
<td>Fresh EBT</td>
<td>Free downloadable smartphone app that connects members using SNAP (Supplemental Nutrition Assistance Program) to their balances, stores that accept SNAP, grocery store deals and offers healthy meal ideas and how to prepare.</td>
</tr>
<tr>
<td>Health4Me Mobile Application</td>
<td>Members can download the app to their smartphone to help them manage their health.</td>
</tr>
<tr>
<td>Podiatry Visits</td>
<td>Members 21 and older can get up to two podiatry visits annually.</td>
</tr>
<tr>
<td>Vision</td>
<td>Members are eligible for upgraded or replacement prescription eyeglass lenses every 12 months.</td>
</tr>
<tr>
<td>MyHealthLine Cell Phone</td>
<td>Members who are eligible can get a free cell phone and service. This benefit includes up to 350 minutes of talk time, 500MB of data, and unlimited texts each month. <em>Includes unlimited calls to Member Services: 1-877-542-9238. Go to <a href="http://www.UHCMyHealthLine.com">www.UHCMyHealthLine.com</a> to complete application.</em></td>
</tr>
</tbody>
</table>
## Value Added Benefits: UnitedHealthcare

### Members on Waiver Programs

<table>
<thead>
<tr>
<th>Value-Added Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Parks and Recreation Catalog Offering</td>
<td>Adult members who are FE, PD members can get access to one activity per member per year with their selected local Parks and Recreation Department. This benefit covers up to $50 per member to participate in local activities.</td>
</tr>
<tr>
<td>MyHealthLine Cell Phone</td>
<td>Members who are eligible can get a free cell phone and service. This benefit includes up to 350 minutes of talk time, 500MB of data, and unlimited texts each month. Includes unlimited calls to Member Services: 1-877-542-9238. Go to <a href="http://www.UHCMyHealthLine.com">www.UHCMyHealthLine.com</a> to complete application.</td>
</tr>
<tr>
<td>Dentures</td>
<td>FE members may be eligible to receive one full set of dentures every five years at no cost. Members work with their care coordinators to arrange for the service.</td>
</tr>
<tr>
<td>Home Helper Catalog</td>
<td>PD, FE, I/DD members can select one product from a catalog of items per year that helps with home safety or home assistance. The member's care works with the member to help them select and order the item. The selected item is sent to the member's home.</td>
</tr>
<tr>
<td>Pest Control</td>
<td>HCBS members who own their own home are eligible for up to two services a year. The member's care coordinator must assess the situation and arrange for the pest control service.</td>
</tr>
<tr>
<td>Transportation to Job Related Activities</td>
<td>PD, TBI, I/DD Waiver members, Kansas residents under WORK as well as some members with behavioral health needs are eligible for six one-way or three round trip rides to work or job interview. Members can call Member Services at 1-877-542-9238 at least three days in advance, to set up a ride.</td>
</tr>
</tbody>
</table>

### Members with Intellectual and Development Disabilities

<table>
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<tbody>
<tr>
<td>Respite Care</td>
<td>Up to 40 hours of respite care is available for I/DD Waiver members living in a family home. The member’s care coordinator assists them with accessing the respite services using a current I/DD respite provider. The member must have a direct service worker, and either personal care attendant services or supported home care. The service does not need to be approved by the CDDO.</td>
</tr>
<tr>
<td>Transportation to Job Related Activities</td>
<td>PD, TBI, I/DD Waiver members, Kansas residents under WORK as well as some members with behavioral health needs are eligible for six one-way or three round trip rides to work or job interviews. Member can call Member Services at 1-877-542-9238 at least three days in advance, to set up a ride.</td>
</tr>
<tr>
<td>Home Helper Catalog</td>
<td>PD, FE, I/DD waiver members can select one product from a catalog of items per year that helps with home safety or home assistance. The member’s care works with the member to help them select and order the item. The selected item is sent to the member’s home.</td>
</tr>
<tr>
<td>MedicAlert Bracelet</td>
<td>Medical Alert Bracelets for members with Autism and IDD.</td>
</tr>
</tbody>
</table>
# Value Added Benefits: UnitedHealthcare

## Behavioral Health Education

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Mental Health First Aid</td>
<td>Mental health first aid is an interactive course designed to mimic standard first aid training. It teaches the general public how to identify, understand, and respond to signs of mental illness and substance use issues. Those who take the 12-hour course to certify as Mental Health First Aiders learn a five-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social and self-help care.</td>
</tr>
</tbody>
</table>

## Kids Age 3 to 19

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</tr>
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<tbody>
<tr>
<td>A is for Asthma Newsletter</td>
<td>Children ages 1 to 4 will receive the A is for Asthma newsletter with tips on managing their condition, presented by Sesame Street characters.</td>
</tr>
<tr>
<td>Sesame Street Food for Thought</td>
<td>Families with children ages 2 to 8 can participate in this interactive program at designated locations throughout Kansas several times during the year. A Sesame Street character participates in the program to teach families how to eat healthy while staying on a budget.</td>
</tr>
<tr>
<td>Youth Organization Activities</td>
<td>Members up to age 18 will be able to get access to youth programs located throughout Kansas such as 4-H, Boys and Girls Clubs, the YMCA and participating Parks and Recreation Offices. Call Member Services to get the form to take to the location.</td>
</tr>
<tr>
<td>KidsHealth</td>
<td>KidsHealth provides children, teens and their parents with over 200 videos and 10,000 written or spoken articles on a variety of wellness topics to help member manage their health conditions and encourage healthy behaviors.</td>
</tr>
</tbody>
</table>

## Moms and Babies

<table>
<thead>
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</tr>
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<tbody>
<tr>
<td>Baby Blocks</td>
<td>Members can earn great rewards with Baby Blocks™. Join Baby Blocks and get a $20 gift card or diaper bag. If a member stays with the program until her baby is 15 months, she can earn up to eight rewards. Members register at uhcbabyblocks.com.</td>
</tr>
<tr>
<td>Community Baby Showers</td>
<td>UnitedHealthcare Community Plan sponsors community events for pregnant and new moms to learn about health and wellness for themselves and their babies. Events are held at various locations statewide. Members can call Member Services for details.</td>
</tr>
<tr>
<td>Infant Care Book for Pregnant Women</td>
<td>Each pregnant member will receive the “Baby Basics” book.</td>
</tr>
<tr>
<td>Mosquito Repellent</td>
<td>Pregnant members can use their Pharmacy benefit to buy OFF Brand Bug Spray to help protect against mosquito bites.</td>
</tr>
</tbody>
</table>
Questions?