



Healthy Blue

Kansas | Healthy Blue | Medicaid • Medicare Advantage

2026 Provider Orientation

Agenda

- Healthy Blue
- Introduction to KanCare and provider resources
- Provider enrollment
- Access and availability
- Value-based programs and quality
- Cultural competency
- Member verification and eligibility
- Availity Essentials
- Prior authorization
- Claim submission information
 - Submission and reimbursement
 - Timely filing
 - Rejected versus denied claims
 - Provider grievances, reconsiderations, and appeals
 - External third-party reviews
 - State fair hearings
 - Fraud, Waste, and Abuse policy
- KAN Be Healthy/Early and Periodic Screening, Diagnostic, and Treatment
- Advance directives
- Member value-added benefits and Healthy Rewards
- Healthy Blue Full Dual Advantage (HMO D-SNP)
- Provider resources

Introduction to KanCare and provider resources



Kansas roots and the Medicaid experience



80+ years in
Kansas

30+ years of Medicaid
experience



State Priorities

Member experience

- Increase member satisfaction
- Improve health outcomes
- Reduce health disparities

Care provider experience

- Increase care provider satisfaction
- Expand network
- Expand workforce

Program improvement

- Cost-effective strategies
- Advanced payment models
- Ability to advance the state's vision

KanCare

KanCare is the Medicaid and Children’s Health Insurance Program (CHIP) managed care program that integrates physical, behavioral, and pharmacy services. KanCare programs also include long-term services and supports (LTSS), home- and community-based services (HCBS) for those qualifying for certain waivers, nursing facility care, and private intermediate care facilities (ICF) for people with intellectual or developmental disabilities (IDD).

KanCare populations:

- Temporary assistance for needy families (TANF)
- Pregnant women
- Newborns
- Foster care children
- Children from families receiving adoption support
- Those receiving Supplemental Security Income (SSI)
- Those dually eligible for Medicare and Medicaid



Health Care Networks Team

Provider relationship account management (PRAM) territory map

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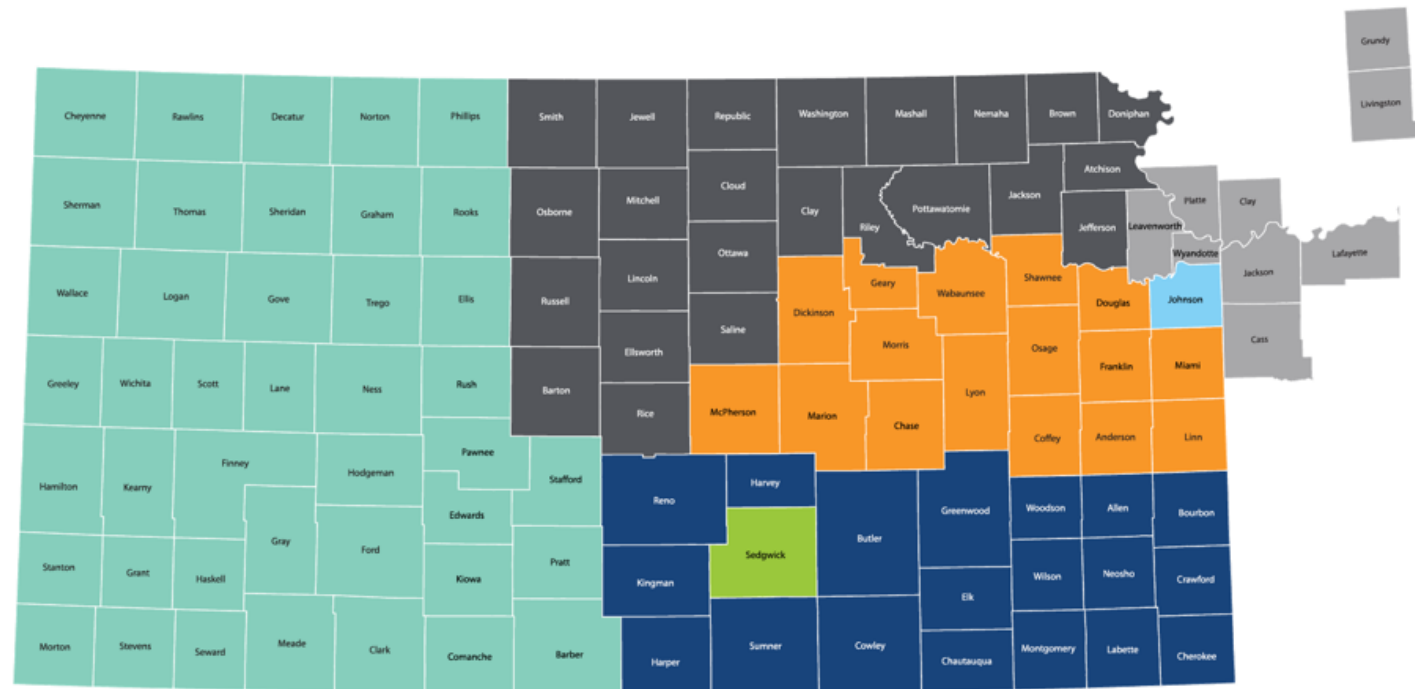
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Carelon Behavioral Health Team

Behavioral Health Provider relationship territory map and representatives



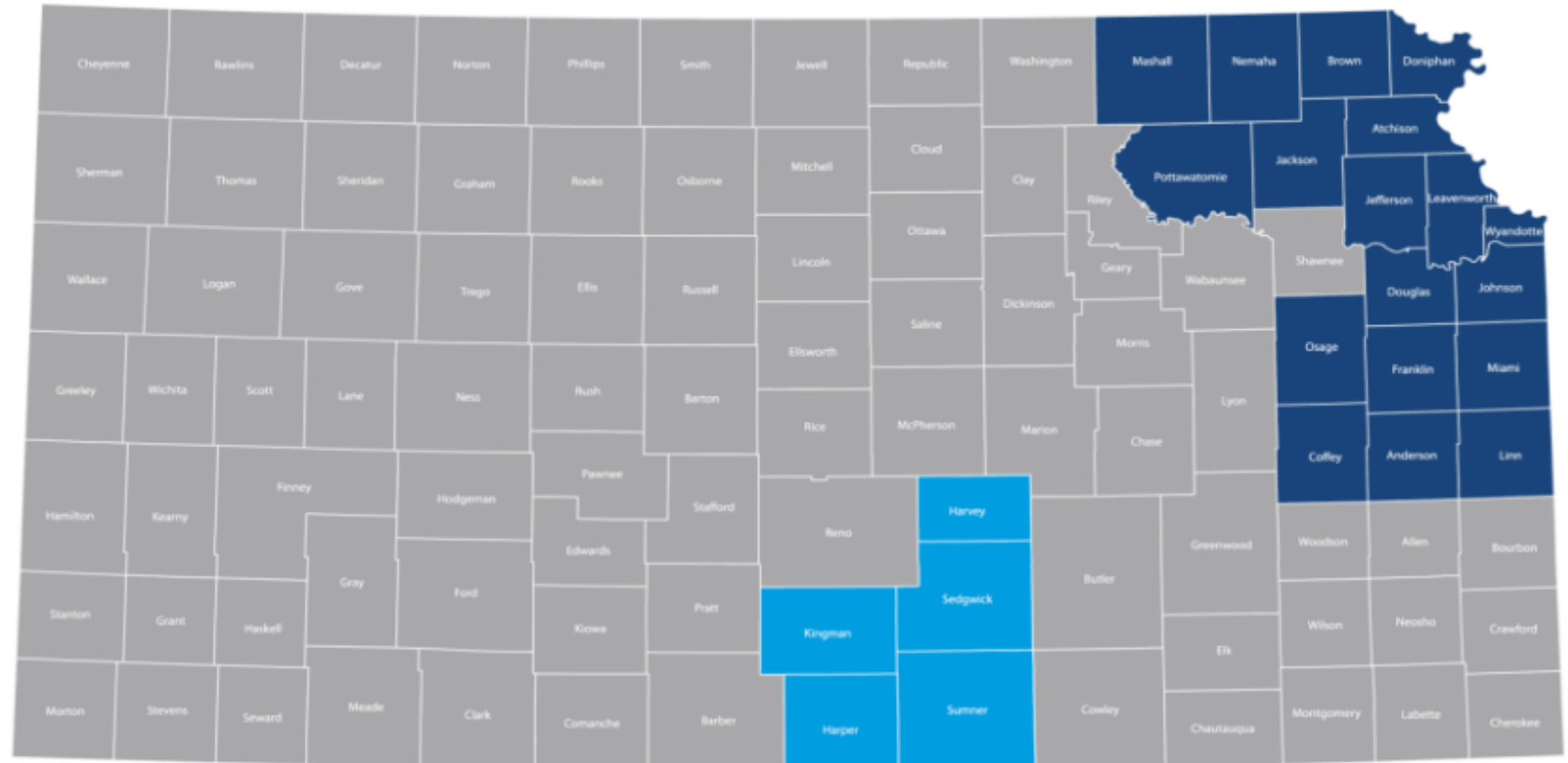
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Long-term support services (LTSS) Team



LTSS Network Relations Specialists:

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Healthy Blue partners

- **Carelon Behavioral Health:**
 - Integrated behavioral health and substance use disorder services
 - Phone: **833-838-2595**
- **CarelonRx:**
 - Pharmacy preapproval services
 - Electronic preapproval via covermy meds.health
 - Retail preapproval PA fax: **877-941-9901**
 - Medical injectable preapproval fax: **877-941-9841**
 - Retail and Medical injectable Preapproval phone: **833-838-2595**
- **SKYGEN:**
 - Dental
 - Phone: **855-434-9237**
- **EyeMed:**
 - Vision
 - Phone: **844-844-0928**
- **MTM:**
 - Non-emergent medical transportation
 - Phone: **833-270-2254**

Translation services

- Translation services are available Monday through Friday, 8 a.m. to 5 p.m. CT:
 - Provider Services:
833-838-2595
 - Member Services:
833-838-2593 (TTY 711)



Kansas Medical Assistance Program (KMAP) Wizard

- The KMAP Wizard is the state's web-based Medicaid provider enrollment system:
 - All providers serving Medicaid members must be screened and enrolled through this system

[Provider Home \(kmap-state-ks.us\)](http://kmap-state-ks.us)

- Provider Training – Provider Portal Reference:
 - [Provider Help Info \(kmap-state-ks.us\)](http://kmap-state-ks.us)

Provider Home



Step one — KMMS provider enrollment

To become a Healthy Blue Medicaid participating provider, work with the Provider Enrollment portal

Complete the following tasks via the KMAP/KMMS Provider enrollment portal:

- Complete the KMMS Provider Enrollment process for your provider/facility (new providers to Medicaid).
- Complete the MCO contract request form for your provider facility (existing Medicaid providers new to an MCO).
- If individual group members are joining or leaving a practice, providers **must** notify the KMMS Provider enrollment portal by updating their effective and end dates with your group.
- All provider updates must be made directly within the KMMS Provider Enrollment portal. All information will then be communicated to Healthy Blue.

Provider enrollment



Step two — Managed care organization provider credentialing

All provider recredentialing is completed by the managed care organizations (MCOs) as part of the KMMS Provider Enrollment process

Important notes:

- KMMS Provider Enrollment and MCO credentialing are two separate actions; both are required prior to MCO contracting.
- All information and documentation submitted as part of KMMS enrollment will be shared with selected MCOs. However, MCOs may still require additional information to complete credentialing. Please respond to the request for additional credentialing documents promptly, so as not to delay credentialing
- A credentialing decision will be made 45 days after Healthy Blue receives all required credentialing documents.

Step three — Contracting with Healthy Blue

- Once a provider receives a credentialing pass status, our contracting team will generate an electronic contract that will be sent via email for signature from OneSpan Sign (signers@esignlive.com).
- Providers should watch for this email and follow the instructions within the message to review and electronically sign the agreement.
- If the provider is linked to an existing contracted group or facility, the provider will be added to the applicable group or facility contracts rather than receiving a separate individual contract.
- If the provider is affiliated with an existing contracted group or facility, the provider must ensure that this affiliation is accurately reflected and updated in the KMAP portal.

Access and availability



Provider access and availability

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

Responds to referrals 24/7 and provides access to evening and weekend care (after-hours)

Responds to routine, urgent, and emergent needs within allowed timeframes:

- 3 weeks for a routine/regular appointment
- 48 hours for Urgent Care
- Waiting times for an appointment should not exceed 45 minutes
- Specialty Care providers are allowed 30 calendar days for a routine/regular appointment

As part of our commitment to providing the best quality provider networks for our members, we conduct annual phone surveys to verify provider appointment availability and after-hours access.

Access-to-care standards

Women's health specialist:

- Newly diagnosed pregnancy (within the first trimester or within 10 calendar days of notification)
- First trimester (within 14 days of request)
- Second trimester (within seven days of request)
- Third trimester (within three days of request)
- High-risk pregnancies (within three days of high-risk identification)
- Postpartum exam (between seven and 84 days after delivery)

After-Hours Expectations for primary and specialty care providers:

- Providers must make available non-emergency after-hours physician or primary care services.
- When a member calls your office after hours, they should be routed to an answering service or given clear instructions for reaching the on-call physician; at a minimum, the message should direct them to call 911 or go to the emergency room.

Value-based programs and quality



Provider value-based performance (VBP) opportunities and supports

Kansas VBP Priority Areas		
 Access, wellness, and preventive care <ul style="list-style-type: none"> • HEDIS® Pay for Quality Provider Incentive Program (P4Q) • Provider Quality Incentive Program (PQIP)† • PQIP Essentials (PQIP-E)† • Negotiated Risk/Shared Savings (NR/SS)† 	 Behavioral Health <ul style="list-style-type: none"> • BH Quality Incentive Program (BHQIP) • BH (Inpatient) Facility Incentive Program (BHFIP) • BH Emergency Department Incentive Program (BHEDIP) • Integrated Care Quality Incentive Program (ICQIP) • Substance Use Disorder Facility Incentive Program (SUDFIP) 	 Maternal and child health <ul style="list-style-type: none"> • Obstetrician Quality Incentive Program (OBQIP)
 Rural health outcomes <ul style="list-style-type: none"> • PQIP Essentials (PQIP-E)† • Pay for Quality (P4Q) 	 Long-Term Care <ul style="list-style-type: none"> • Nursing Facility Quality Incentive Program (NFQIP) • Personal Attendant Care Quality Incentive Program (PACQIP) 	 Social Determinants and supports <ul style="list-style-type: none"> • Social Determinants of Health Provider Incentive Program (SDOHPIP)

†Above LAN category 2

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Quality program pillars

Quality Program Pillars



Several methods are used to monitor monthly performance against targets:

- The quality management team reviews metrics using our NCQA-certified HEDIS reporting platform to analyze trends.
- Provider success consultants work with VBP providers reviewing monthly scorecards on our Availity platform.
- Providers can access member-level detail on gaps in care to focus outreach.
- Performance reports are run monthly to compare provider performance against targets.
- Monthly surveys gather direct member feedback on their care experience.

Cultural competency



Cultural competency

- Healthy Blue is committed to culturally responsive care by understanding how culture and ethnicity shape members' needs and experiences, so every member receives equitable, effective healthcare.
- We expect our providers and their staff to share our commitment.
- Resources, training material, and information are available online, including:
 - The My Diverse Patients website: <https://www.healthybluekansas.com/provider/state-federal/resources/training-academy/serving-diverse-populations>
 - Self-assessment tool
 - Cultural competency tool kit
 - Cultural competency training

Member verification and eligibility



Verifying eligibility and MCO assignment

Options for checking Eligibility and why it is important

- KMAP website (**preferred method**)
- MCO options available for verifying eligibility
- EDI transactions (270/271 transactions)
- KMAP Automated Voice Response System (AVRS)
- KMAP Provider Services Call Center
- MCO Provider Services Call Center

Because Medicaid eligibility can change monthly, providers should verify eligibility at the start of each month and before providing services.

Using the KMAP/KMMS Secure Portal to verify eligibility lets providers confirm a member's coverage and MCO assignment for the date of service, helping ensure claims are submitted correctly for faster, more accurate processing. There are several great training resources for the KMAP portal available here:

<https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderHelpfulInfo>

Determining member eligibility and coverage

Healthy Blue and other MCOs also provide the same benefits to Medicaid members. All benefits allowed via Medicaid (KMAP) are provided with the same rules and expectations through the MCOs.

The best way to confirm whether a service code is covered for a member is through the KMAP Provider Portal:

- Interactive tools – HCPCS Procedure code look-up tool (**preferred method**)
- KMAP Provider Manuals

Other options for verifying coverage of services:

- Healthy Blue Provider Manual
- Healthy Blue Provider Services Call Center

Please note: Providers need to verify coverage of a code or service before requesting a prior authorization. Prior authorization is not a verification of coverage or a guarantee of payment.

Availity Essentials



Availity Essentials

Healthy Blue has designated Availity Essentials to operate and service your electronic data interchange (EDI) entry point (EDI gateway) and other self-service tools. Registration for the secured content on the Availity Essentials platform is easy.

Online claims submission

Use our free online claim submission tool at <https://Availity.com>. You can submit claims, see statuses, dispute claim payment, use Clear Claim Connection, and more. **Claims must be submitted using the state-issued Member ID that starts with 001 and has 11 digits.**

Eligibility verification and prior authorization

You can verify member eligibility and submit authorizations by searching the Healthy Blue subscriber or state-issued identification number. Submit prior authorization requests online through <https://Availity.com>, by fax, or by calling Provider Services at **833-838-2595**.

Demographic changes

Please update your demographic information with the KMAP. You can contact KMAP directly at **800-933-6593** or visit their website at: [KMAP Portal](#).

Visit the Availity Essentials website for additional resources.

Support: Availity Client Services is available at **800-282-4548 (800-AVAILIT)** Monday to Friday, **9 a.m. to 6 p.m. CT.**

Availity Essentials — Patient360

Patient360 is a tool within the Availity Essentials platform that provides an in-depth view of the treatment and care your patient is receiving. This tool allows all providers to view information regarding patient demographic information, pharmacy details, authorizations on file, and claim summaries (such as which other providers the patient is seeing).

Improving provider-to-provider communication eliminates barriers when coordinating member care, improves the quality of care a member receives, and improves the member experience.

- To access Patient360, log in to <https://Availity.com>.

For more information about Availity Essentials or to find training, please access the following link:
<https://www.healthybluekansas.com/provider/state-federal/resources/learn-about-availity>

Prior authorization



Prior authorizations

To determine whether a specific outpatient procedure and/or service requires prior authorization, use the prior authorization lookup tool. This tool allows you to search by market, member's product, and CPT® code.

The Kansas Medicaid Universal Prior Authorization Form, Medical Policies, UM Criteria, and the Precertification Lookup Tool can be viewed and downloaded on the provider website, <https://www.healthybluekansas.com/provider/state-federal/resources/prior-authorization-requirements/lookup-tool>.

- All inpatient stays require preapproval.
- All out-of-network providers are required to get prior authorization for all services.
- Emergency services do not require prior authorization.

Required prior authorization documentation

A completed prior authorization request is required to eliminate delays in the process. A completed request includes all required information, documentation, current clinical information, and a signed authorization form by the requesting provider:

- **Please note: obtaining a preapproval is not a guarantee of payment.**

To prevent delays, the following information must be included to allow for timely processing:

- The requesting provider's name, NPI, TIN, and signature.
- The rendering provider's name, NPI, and TIN.
- The diagnosis code, CPT code, HCPCS code, or Current Dental Terminology (CDT).
- The service request start and end date and quantity of service units requested based on the CPT® code, HCPCS code, or CDT requested.
- The member's name, date of birth, and the Healthy Blue subscriber and state-issued identification number.

Prior Authorization medical necessity criteria

Criteria guidelines for each physical and behavioral health request are determined by using the clinical hierarchy below and can be found on our [provider website](#):

- Federal Medicaid mandates and EPSDT guidelines
- State guidelines such as manuals, contracts, policies, and benefits
- MCG inpatient and surgical care, general recovery care, ambulatory care, recovery facility care, home care, behavioral healthcare, chronic care, and chronic care guidelines
- Healthy Blue Medical Policies
- Healthy Blue Clinical UM Guidelines
- American Society of Addiction Medicine (ASAM) criteria
- Carelon Medical Benefits Management Guidelines

Prior Authorization process for retro-active members

A retroactive prior authorization request is needed for a member who was deemed retroactively eligible by the state of Kansas:

- Requests can be made after the service is provided, but must be submitted prior to the claim being submitted.
- Retroactive prior authorization requests should be submitted via the normal submission process, but clearly labeled as *retro eligible member*.
- The request must include documentation showing the member was retroactively eligible, which is typically the state notification.



Prior authorization: important contact information

If you have questions, contact Provider Services at 833-838-2595. Staff are available Monday through Friday, 8 a.m. to 5 p.m. CT, excluding state-observed holidays.

Digital submissions via <https://Availity.com> are the preferred method.

Inpatient/outpatient surgeries:	800-964-3627 (fax); 800-454-3730 (phone)
Emergent/concurrent inpatient services:	866-852-2608 (fax)
Outpatient services:	866-852-2844 (fax)
Therapy services:	877-371-0393 (fax)
Behavioral health services:	<ul style="list-style-type: none">• Behavioral health (inpatient): 866-852-8976 (fax)• Behavioral health (outpatient): 866-852-8978 (fax)• Digital submission (preferred method) at https://Availity.com
Carelon Medical Benefits Management	careloninsights.com (online): <ul style="list-style-type: none">• Cardiology• Genetic testing• Musculoskeletal• Radiation oncology• Radiology (high-tech)• Sleep studies

Prior authorization: important contact information (cont.)

Contact information	
Dental (provided through SKYGEN)	855-434-9237 (phone)
Routine vision/medical/surgical (provided through EyeMed)	844-844-0928 (phone)
Pharmacy (provided through CarelonRx)	Pharmacy Benefit: <ul style="list-style-type: none">• Electronic PA (e-PA) via CoverMyMeds (covermyeds.health)• 877-941-9901 (fax)• 833-838-2595 (phone) Physician Administered Drugs Medical Benefit: <ul style="list-style-type: none">• Electronic PA (e-PA) via CoverMyMeds (covermyeds.health)• 877-941-9841 (fax)• 833-838-2595 (phone)
Non-emergency medical transportation (provided through Access2Care an MTM Company)	833-270-2254 (Member & Provider Services) access2care.net
Nurse Helpline	833-838-4344 (phone)

Peer-to-peer review

Office staff may call on the requesting provider's behalf to schedule a peer review with our medical director.



Contact

- Physical health: 833-838-9339
- Behavioral health: 833-838-9119

Documentation

- Gather the names of the individual or the physician our medical director needs to call.
- Provide the date and time for a callback.
- Reference or case ID
- Member's name, date of birth, and subscriber ID number

Wait for call

- Our medical director will make every effort to call back within one business day.

Disputes

- You may request a peer-to-peer review within two business days of receiving an authorization denial for reconsideration.
- After two business days, the case will need to follow the appeal process outlined in the letter received if no action is taken by your organization or provider.

Claims submission information



Claim submission and reimbursement policies

- Electronic Data Interchange (EDI): electronic claims through a vendor or your EHR
- Availity Essentials
- KMAP Portal:
 - KMMS login page, claims for Healthy Blue submitted to Gainwell through KMAP will be routed to Healthy Blue.
- Paper

Paper submissions	Electronic submission payers	EDI Hotline
Healthy Blue P.O. Box 61010 Virginia Beach, VA 23466-1010	<ul style="list-style-type: none">• Availity Essentials: 800-282-4548• Website: https://Availity.com• Payer ID: 00047	<ul style="list-style-type: none">• Phone: 800-282-4548

Timely filing

New day claims (initial claim submission)

The timely filing requirement is 180 calendar days from the date of service for the initial correct claim.

Corrected claims

For a claim that is corrected with Healthy Blue if the original claim was processed and paid incorrectly, the timely filing requirement is 365 calendar days from the date of service

Claims impacted by a member with retroactive eligibility

A provider has 180 calendar days from the date the member was deemed eligible by the state of Kansas to file their initial claim. A provider must obtain a copy of the eligibility determination letter from the member or contact KMAP Provider Services to obtain the eligibility determination date.



Rejected versus denied claims

What is the difference between a rejected and a denied claim?

- Rejected claims:
 - A rejected claim is a claim that does not enter the claims processing system due to missing or incorrect information.
 - Since the claim does not enter the claims processing system, it will not register as an initial claim submission for timely filing purposes.
 - The claim will not appear on a provider remittance advice.
 - Providers will need to work their EDI rejections report (999 report) to identify why claims are rejected
- Denied claims:
 - Claims that do go through the claims processing system are denied.
 - The claim will register in our system on the date we received it for the purposes of timely filing.
 - The claim will appear on a provider remittance advice.

Electronic remittance advice and electronic funds transfer enrollment

Electronic remittance advice (ERA) (835):

- The 835 eliminates the need for paper remittance reconciliation.
- Use Availity Essentials to register and manage ERA account changes with these easy steps:
 - Log in to <https://Availity.com>.
 - Select My Providers > Enrollment Center > ERA 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 EFT is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 ERA for simple payment reconciliation.
- Use [EnrollSafe \(payeehub.org\)](https://payeehub.org) to register and manage EFT account changes.

Provider grievances (non-claim)

Provider grievances must be submitted within 180 calendar days of the incident:

- Examples of grievances include:
 - Credentialing processes.
 - Authorization process difficulties.
 - Member/associate behavior concerns.
 - Inaccuracies in printed materials or inconsistent messaging.
- Grievances are resolved fairly and are consistent with our policies and covered benefits.

Verbal provider grievances:

- Call Provider Services at **833-838-2595**
- Call your local provider relationship management representative.

Written (not required) provider grievances:

- Email your provider relationship management representative
- Email: KansasProviderGA@healthybluekansas.com
- Choose non-claims provider grievance in <https://Avality.com>

Provider reconsiderations

Provider reconsiderations have a 123-calendar-day filing deadline from the date of the provider remittance advice. Reconsiderations can be submitted in one of the following ways:

- Through the payment dispute application in Availity Essentials.
- By calling **833-838-2595**.
- By printing the forms from the provider website and mailing them to:
 - Healthy Blue
Payment / Service Appeals
P.O. Box 61599
Virginia Beach, VA 23466-1599

If a provider chooses to request reconsideration, the provider may cancel the reconsideration process and submit an appeal request within 60 calendar days of the date of the Notice of Action, plus an additional three calendar days to allow for sending of the notice.

Provider appeal

The provider must submit an appeal request within 63 calendar days of the Notice of Action or 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 application to initiate the appeal at <https://Availity.com>.
- Locate the claim you want to dispute using the *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.

For a written appeal:

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

External third-party review

- If you do not agree with an appeal 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 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 of receipt.

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

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

State fair hearing

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). Providers may file their request via:

- Fax: **785-296-4848**
- Mail: 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, 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

Fraud, Waste, and Abuse

Help us prevent fraud, waste, and abuse, and tell us if you suspect it:

- Verify member identity.
- Ensure that services are medically necessary.
- Document medical records completely.
- Report suspected fraud to **866-847-8247** or to Provider Services.

- Call the Kansas Attorney General Hotline at **866-551-6328** or **785-368-6220**.
- Visit [Medicaid OIG](#).
- Report directly to your health plan compliance officer.
- Provider Services: **833-838-2595**
- Please visit the Healthy Blue website for additional information.
- Learn more at fighthhealthcarefraud.com.

Pharmacy information



Pharmacy

- **Drug coverage alignment with the Kansas Department of Health and Environment (KDHE):**
 - State Formulary — covered drug list.
 - State Preferred Drug List (PDL) includes the preferred drugs within the most prescribed therapeutic categories. Non-preferred drugs require prior authorization.
- **Drug prior authorization alignment with KDHE:**
 - Use state prior authorization criteria.
 - Use state prior authorization forms.
- **Provider tools:**
 - Real-time benefit check — PDL integrated in the e-prescribing tool
 - Provider website:
 - Formulary lookup tool [Main | Formulary Search](#)
 - Link to state PDL [Preferred-Drug-List-PDF](#)
 - State prior authorization criteria and forms [Clinical-PA-Drug-Index-PDF](#)
 - Medical Injectable drug prior authorization look up tool <https://www.healthybluekansas.com/provider/state-federal/resources/prior-authorization-requirements/lookup-tool>

KAN Be Healthy/Early and
Periodic Screening, Diagnostic,
and Treatment



KAN Be Healthy/Early and Periodic Screening, Diagnostic, and Treatment

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), also known as KAN Be Healthy, is for members under 21 years of age who are eligible for CHIP or Medicaid.
- KAN Be Healthy provides regular medical, dental checkups, and case coordination services to members under 21 years of age.
- Healthy Rewards are available for members who complete well-child checks, immunizations, and lead screenings.



Kan Be Healthy/EPSTD (cont.)

Coverage of medically necessary services:

Services deemed medically necessary during an EPSTD 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 prior authorization.

Under EPSTD, non-covered services may be covered for members when services are determined to be medically necessary.

The EP modifier will be used to distinguish non-covered state plan services that are deemed medically necessary for coverage under the EPSTD benefit. Medical necessity must be established, and prior authorization must be obtained.

For more information on EPSTD, please see the Kan Be Healthy manual on KMAP:

https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/KBH_25291_25224.pdf

Advanced directives



Advance directives

- An advance directive is a written legal document, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated.
- A living will allows people to determine what medical treatments they wish to receive at the end of their life.
- A medical durable power of attorney allows the member to appoint a trusted individual to oversee their medical care and make healthcare decisions for the member if they are unable. The person chosen to speak for the member is called a healthcare agent.
- You will find more information in the provider manual on our website at healthybluekansas.com/provider.

Member value-added benefits and Healthy Rewards



Member value-added benefits

Value-added benefits (VABs) provide support beyond standard benefits, encouraging members to check eligibility and claim their benefits on their online website or in their Sydney app:

- **Over the counter (OTC) + Personal Care Card** — A \$75 gift card for OTC and hygiene supplies. Available to all members who have completed a well visit.
- **Free diapers** — One pack of diapers per quarter through age one (up to 800 diapers). First and second sets available after baby's first well-visit, third and fourth sets available after baby's second well-visit.
- **Dental + vision extras (Adults 21+)** — Provides an extra \$500 per year toward dental services + \$75 per year toward contacts or additional frames.
- **Transportation support** — Up to \$75 a year for a rideshare gift card, a gas card, a gift card for an oil change, a public transit gift card, or an AAA membership. We also offer 30 round-trips per year or 60 one-way trips for groceries, job interviews, support groups, and more.
- **Healthy lifestyle aids** — Eligible members can choose one item per year (BP monitor, scale, insoles) worth up to \$75.
- Plus dozens more value-added benefits. A full list is available here: [638980228887470000](https://www.638980228887470000.com)

Healthy Rewards

Members can earn gift cards for completing key visits and screenings.

- Prenatal visit (within first trimester): \$50 (one per pregnancy)
- Postpartum visit (between 7-84 days after delivery): \$50 (one per pregnancy)
- Well-child visits (0-30 months): \$10 per visit (max \$60; up to five visits)
- Well-child visit (ages 3-17): \$50 (one per member)
- Lead screening (completed by 2nd birthday): \$25 (one per member)
- Childhood immunizations Combo 10: \$25 (one per member)
- 2nd HPV vaccination (completed by 12th birthday): \$25 (one per member)
- Annual adult exam: \$15 (one per 12 months)
- Health screener: \$25 (one per 12 months)
- Influenza vaccination: \$25 (one per 12 months)
- Diabetic A1c screening: \$25 (one per 12 months)
- Diabetic retinal eye exam: \$25 (one per 12 months)
- Annual dental exam (ages 0-20): \$25 (one per 12 months)

Members track and redeem Healthy Rewards in their member portal or in their Sydney Health App. Gift card selection may vary.

Additional member benefits

Virtual and digital programs at no cost to eligible members.

Pomelo Care (Pregnancy + newborn support):

- 24/7 virtual pregnancy and infant care — text, call, or video with a care team.
- Help from doctors, nurses, lactation consultants, and other specialists.
- Members can get started: pomelocare.com/healthybluekansas or call or text: 913-258-1444.

Learn to Live (digital mental health):

- Online programs for depression, stress/anxiety, insomnia, substance use, resilience, and more.
- No cost. Coaching available via text, email, or phone.
- Members can get started: learntolive.com/welcome/KSHEALTHYBLUE (code: KSHEALTHYBLUE).

NourishedWell/Foodsmart (nutrition coaching):

- 1:1 coaching with a registered dietitian (phone/video) + personalized plan.
- Earn \$25 in Foodsmart Bucks grocery money for each coaching call.
- Members can get started: <https://foodsmart-dev.com/members/healthybluekansas>.

Healthy Blue Full Dual Advantage (HMO D-SNP)



D-SNP



What is D-SNP?

- *D-SNP* stands for **Dual Special Needs Plan**.
- D-SNPs are specialized Medicare plans for people who qualify for both Medicare and Medicaid, also known as *dually eligible* consumers.
- People qualify for Medicaid and Medicare separately.
- D-SNP eligible consumers can include low-income seniors ages 65 and older, and people with disabilities who are younger than age 65.

D-SNP (cont.)

Healthy Blue D-SNP:

- The member can have one carrier for D-SNP and another carrier for Medicaid.
- Members can change D-SNP plans quarterly.
- Healthy Blue is responsible for coordinating care for D-SNP members, regardless of whether we are the member's Medicaid MCO or not.
- Coordination means assisting the members with obtaining the care they need, even if it is not a benefit covered under the D-SNP. It is everyone's responsibility to help and find care. This includes assisting with billing and service.
- D-SNP members should show a provider both D-SNP Medicare and Medicaid ID cards.

Healthy Blue D-SNP data

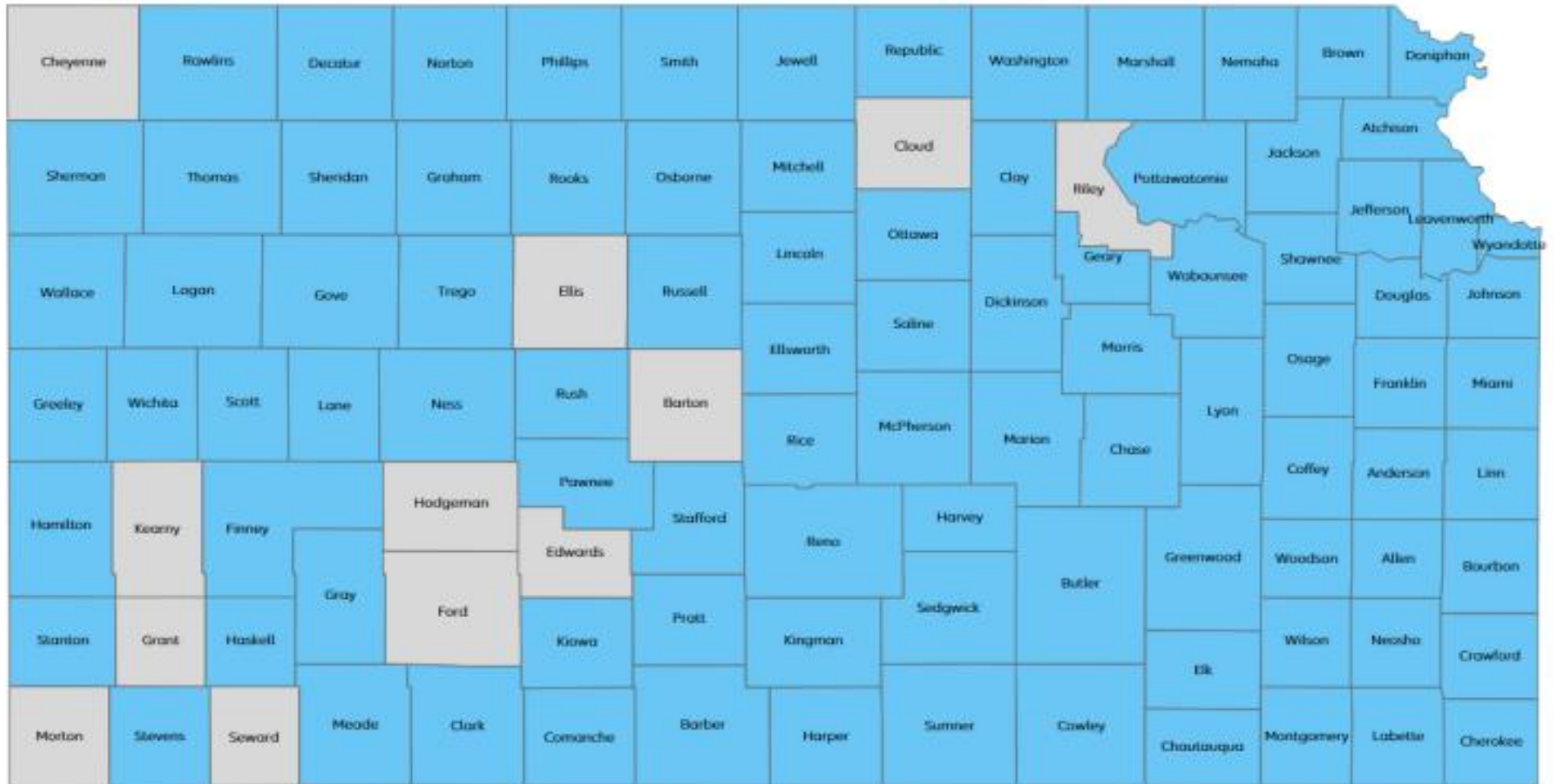
- Healthy Blue provides all data requested for care coordination, Medicaid coverage of Medicare cost share, and/or additional Medicaid benefits, including LTSS and behavioral health services, as defined by their D-SNP eligibility category.
- Members do not have to have Medicare and Medicaid; with Healthy Blue, they can use another carrier for Medicaid.



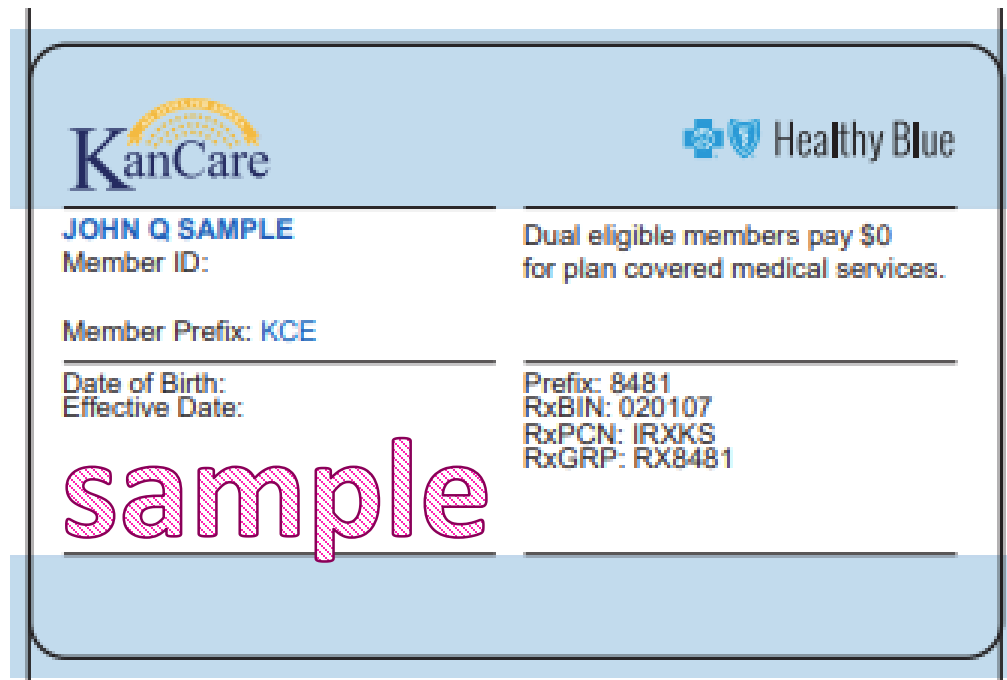
2026 D-SNP service area


D-SNP

SNP
DSNP



Sample D-SNP member ID cards



KanCare 

JOHN Q SAMPLE
Member ID: _____

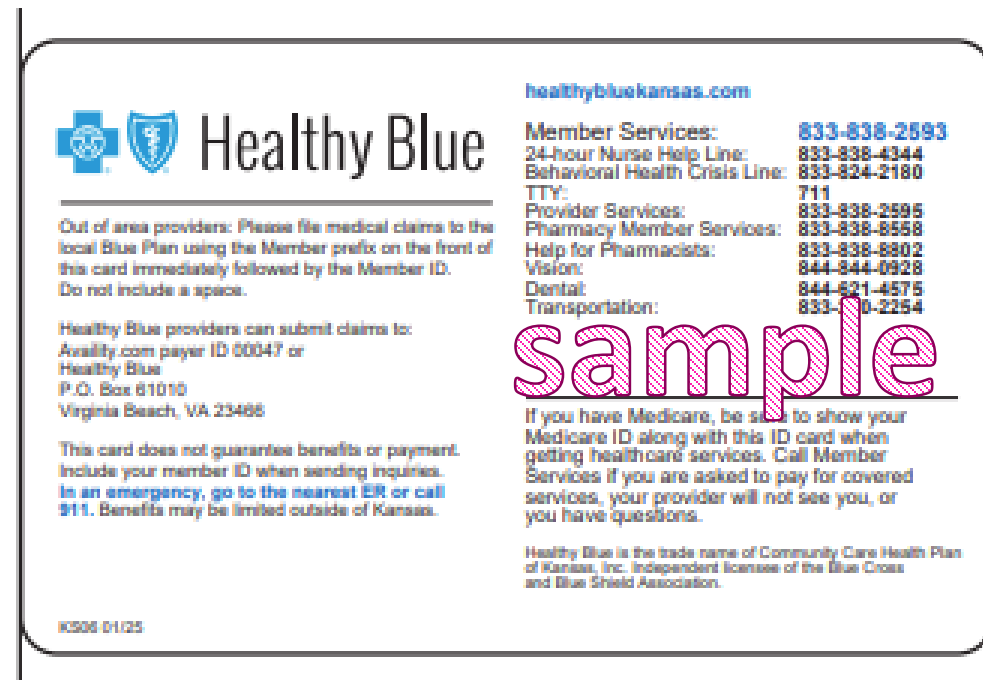
Member Prefix: **KCE**


Date of Birth: _____
Effective Date: _____

sample

Dual eligible members pay \$0 for plan covered medical services.

Prefix: 8481
RxBIN: 020107
RxPCN: IRXKS
RxGRP: RX8481



 **Healthy Blue**

healthybluekansas.com

Member Services: **833-838-2693**
24-hour Nurse Help Line: **833-838-4344**
Behavioral Health Crisis Line: **833-834-2180**
TTY: **711**
Provider Services: **833-838-2595**
Pharmacy Member Services: **833-838-8558**
Help for Pharmacists: **833-838-8802**
Vision: **844-844-0928**
Dental: **844-821-4575**
Transportation: **833-838-2254**

Out of area providers: Please file medical claims to the local Blue Plan using the Member prefix on the front of this card immediately followed by the Member ID. Do not include a space.

Healthy Blue providers can submit claims to:
Avality.com payer ID 80047 or
Healthy Blue
P.O. Box 61010
Virginia Beach, VA 23468

This card does not guarantee benefits or payment. Include your member ID when sending inquiries. **In an emergency, go to the nearest ER or call 911. Benefits may be limited outside of Kansas.**

sample

If you have Medicare, be sure to show your Medicare ID along with this ID card when getting healthcare services. Call Member Services if you are asked to pay for covered services, your provider will not see you, or you have questions.

Healthy Blue is the trade name of Community Care Health Plan of Kansas, Inc. Independent licensee of the Blue Cross and Blue Shield Association.

KS06 01/25

D-SNP provider guidebook

Please refer to the provider guidebook for any questions about operations and procedures related to our D-SNP members. The guidebook provides information on the following:

- Medicare overview
- Expectations and responsibilities as a participating provider
- Provider credentialing information
- Payment disputes/reconsiderations, appeals, and state fair hearing rights
- Fraud, Waste, and Abuse policy
- Additional topics important to our plan

D-SNP claims filing procedures

- Since D-SNP is the primary plan, providers should submit claims to the address on the back of the member's ID card or through Availity Essentials.
- The provider files/submits a claim to Healthy Blue and then submits the EOP along with the claim to the secondary payer (state Medicaid agency or another Medicaid MCO):
 - Timely filing for paper and electronic claims is up to 180 days from the service date.
 - For any corrected claim or other rebilling, the filing limit is 365 days from the date of service.
- The claims platform for both Medicare and Medicaid is the same; Healthy Blue will automatically submit the claim from Medicare to Medicaid for processing:
 - In this instance, the provider would not have to submit a secondary claim with the *EOP*.
- Providers cannot balance-bill D-SNP members:
 - Claims go to Healthy Blue D-SNP as primary and then to Medicaid for secondary processing.
- KMAP will only pay for KMAP-covered services that are also covered by other insurance if the Medicaid payment rate is higher than the amount paid by the primary insurance, and, within this limit, will only pay to the extent necessary to pay the member's cost-sharing liability.

D-SNP claim submission options

- Electronic Data Interchange (EDI)
- Availity Essentials
- Paper
- D-SNP timely filing is within 180 days of the service date.

Paper submissions	Electronic submission payers	EDI Hotline
Healthy Blue P.O. Box 105187 Atlanta, GA 30348	<ul style="list-style-type: none">• Availity Essentials: 800-282-4548• Website: https://Availity.com• Payer ID: 00047	<ul style="list-style-type: none">• Phone: 800-590-5745

D-SNP reimbursement policies

- Providers and facilities are required to use industry-standard codes for claim submissions and should bill according to Medicare guidelines. Services should be billed with CPT codes, HCPCS codes, and/or revenue codes.
- The billed code(s) should be fully supported in the medical record and/or office notes.
- D-SNP information can be found at [Healthy Blue | D-SNP](#).

D-SNP payment reconsiderations and appeals

There are several options when filing a claim payment dispute

Use the Availity Essentials appeal application at <https://Availity.com>.

Supporting documentation can be uploaded on the website.

You will receive immediate acknowledgment of your web submission.

Use the *Chat with Payer* function to chat with a representative.

Mail or fax a Claim Payment/Service Appeal Form or the Reconsideration Form to:

Healthy Blue
D-SNP Reconsiderations & Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

Call and speak with a provider relationship management representative at **833-838-2595**.

D-SNP reconsiderations

Reconsideration requests in writing, verbally, and through our provider web portal are due within 123 calendar days from the date on the *EOP*.



Plan will resolve reconsiderations within 30 calendar days of receipt.



Please refer to the denial notice issued to determine the correct appeals/dispute process.



For more information, please visit our provider guidebook at:
<https://www.healthybluekansas.com/provider/state-federal>

D-SNP claims payment and service appeals

Claims payment and service appeals are due **63 calendar days** of the date of the reconsideration resolution notice.



Include as much information as you can to help us understand why you think the reconsideration determination was in error.



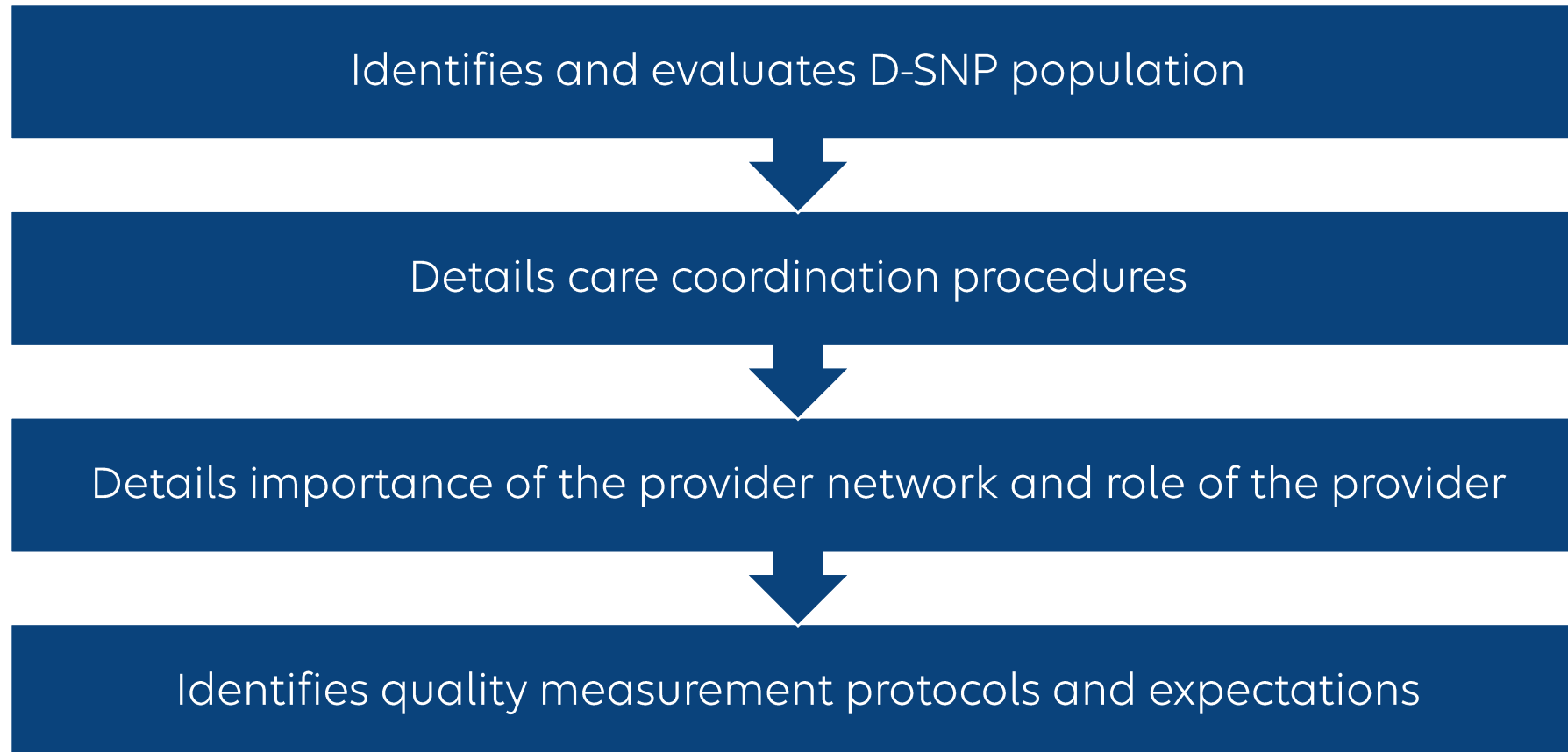
For more information, please visit our provider guidebook at:
<https://www.healthybluekansas.com/provider/state-federal/resources/policies-guidelines-manuals/medical-policies-clinical-guidelines>



The plan will make a determination within **30 calendar days** of receipt.

D-SNP model of care

All D-SNP plans are required to have a model of care that provides the basic framework under which the D-SNP will meet the needs of each of its members, and is a requirement for D-SNP plans by CMS.



D-SNP model of care (cont.)

- The model of care is a vital quality improvement tool and an integral component for ensuring that the unique needs of each member are identified by the D-SNP and addressed through the plan's care management practices.
- The model of care provides the foundation for promoting D-SNP quality, care management, and care coordination processes.
- The Healthy Blue model of care is unique and distinct from our plan, and another payer's model of care cannot be applied to D-SNP.
- **Participating providers are required to take the model of care training annually. The training can be found in our [Training Academy](#).**
- Adherence to our model of care ensures members have improved quality of care and better health outcomes.

D-SNP important links

- Healthy Blue Provider Guidebook: [Healthy Blue providers](#)
- Healthy Blue Full Dual Advantage (HMO-D-SNP) Medical Policies:
 - [Healthy Blue | D-SNP](#)
- <https://Availity.com>



Provider resources



Helpful online resources and telephone numbers

- Healthy Blue: [Kansas Providers | State & Federal Programs | Healthy Blue](#)
- KanCare: kancare.ks.gov or call the KanCare Clearinghouse at **800-792-4884**
- Kansas Medical Assistance Program (KMAP): [KMAP Provider Portal](#) or call **800-933-6593** for Provider Customer Service
- Kansas Department of Health and Environment (KDHE): kdhe.ks.gov or call **785-296-3981**
- KMAP preapproval lines — phone **800-285-4978**, fax **800-913-2229**
- Managed Care Enrollment Center — phone **866-305-5147**
- Kansas Department for Aging and Disability Services: kdads.ks.gov or call **785-296-4986**
- Centers for Medicare and Medicaid Services: CMS.gov
- National Committee for Quality Assurance: ncqa.org

Provider surveys

Healthy Blue will use your survey responses to better understand your experiences, continue to improve our programs, and hold providers accountable for the standards expected by KanCare:

- Annually, Healthy Blue sends out a Provider Satisfaction Survey to engage our provider network to give feedback for improving and strengthening our processes and operations.
- Healthy Blue participates in the Access-to-Care program to measure provider-specific compliance with Access and Availability Standards.
- Training and orientation sessions will end with an opportunity to provide feedback via a survey to our teams.

Please complete all surveys

Next steps

- Complete and submit the Provider Orientation Feedback Survey.
- Submit your Let's Connect Card.
- Register for Availity Essentials.
- Register for electronic data interchange.
- Register for EFT services.
- Read your provider manual.

Thank you for collaborating with Healthy Blue





Healthy Blue

Healthy Blue is the trade name of Community Care Health Plan of Kansas, Inc., an independent licensee of the Blue Cross Blue Shield Association.
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