Home and community-based services
Provider education
Agenda

• KanCare program and member eligibility for waivers
• Member benefits and supports
• Provider responsibilities and actions
• Resources for our providers
The KanCare program is the state’s integrated model for delivering Medicaid and CHIP services. Each Medicaid consumer has been assigned to a managed care plan, and we arrange for the provision of all covered services for our assigned members.
Enrollees in waivers who meet state eligibility requirements for participation in managed care:

• Are automatically assigned to a managed care organization (MCO)
• Have 90 days from their MCO enrollment effective date to change MCOs
• Are automatically assigned to a PCP upon auto-assignment to Amerigroup Kansas, Inc. if enrolled in Medicaid only and not also eligible for Medicare; enrollees may change their PCP thereafter as frequently as desired
• Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment
Waiver programs

- Autism*
- Frail Elderly (FE)
- Traumatic Brain Injury (TBI)
- Technology-Assisted (TA)
- Physical Disability (PD)
- Serious Emotional Disturbance* (SED)
- Intellectual & Developmentally Disabled (IDD)

*Does not apply to Financial Management Services providers.
For all waiver programs:

• Eligibility is determined by the state through functional, income and resource assessments.

• Our case managers will arrange for and complete service coordination. Each individual receiving waiver services has been assigned a service coordinator who will create and sign off on the integrated service plan. The coordinator will assess the member and decide which services best fit the member’s needs.

• The State of Kansas will implement a 1115 waiver. This new waiver would integrate services so that all services would be available to all waiver recipients as found necessary to continue their lives in a community setting. The State of Kansas will continue to post updates on the progress of this implementation.
Autism (AU) waiver*
Age criteria 0-5

Waiver services include:
• Consultative clinical and therapeutic services
• Family adjustment counseling
• Intensive individual supports
• Interpersonal communication therapy
• Parent support and training
• Respite care

*Does not apply to Financial Management Services providers.
Frail Elderly (FE) waiver
Age criteria ≥ 65

Waiver services include:

• Adult day care
• Assistive services (home modifications and equipment)
• Personal care services (agency and self-directed)
• Comprehensive support (agency and self-directed)
• Home telehealth
• Medication reminder services
• Nursing evaluation visit
• Personal emergency response system
• Enhanced care services
• Wellness monitoring
• Financial management services
Traumatic Brain Injury (TBI) waiver
Age criteria 16-64

Waiver services include:

• Assistive services
• Transitional living skills
• Rehabilitation therapies
  o Cognitive rehabilitation therapy
  o Behavior therapy
  o Occupational therapy
  o Speech and language therapy
  o Physical therapy
• Home-delivered meals
• Medication reminder services
• Personal care services (agency and self-directed)
• Enhanced care services
• Personal emergency response systems and installation
• Financial management services
Technology-Assisted (TA) waiver
Age criteria 0-21

• Our case managers will ensure continuity and care transition
• Waiver services include:
  o Health maintenance monitoring services
  o Personal care services
  o Intermittent intensive medical care
  o Specialized medical care (LPN or RN)
  o Medical respite
  o Home modification
• Financial management services
Physical Disability (PD) waiver
Age criteria 16-64*

Services include:

• Assistive services
• Home-delivered meals
• Medication reminder services
• Personal emergency response system and installation
• Personal care services (agency and self-directed)
• Enhanced care services
• Financial management services

*Existing PD waiver members may extend services beyond age 64 without transitioning to the FE waiver
Serious Emotional Disturbance (SED) waiver*

Age criteria 4-18

- Eligibility for the SED waiver will continue to be determined by the state in concert with the Community Mental Health Centers (CMHC)
- We will cover medically necessary behavioral health covered services for members participating in the SED waiver, including all SED waiver services:
  - Wraparound facilitation
  - Personal care §1915(c)
  - Independent living/skill building
  - Short-term respite care
  - Parent support and training
  - Professional resource family care

*Does not apply to Financial Management Services providers.
Intellectual & Developmentally Disabled (IDD) waiver

Age criteria ≥ 5  
(Manifest before 22 years of age)

Waiver services include:

- Residential support
- Day support
- Personal care services
- Respite overnight (agency and self direct)
- Personal assistant (self-directed only)
- Supported employment

- Enhanced care services
- Specialized medical care (LPN or RN)
- Medical alert
- Wellness monitoring
- Assistive services (home modifications and equipment)
- Financial management services
Money Follows the Person (MFP)
This grant serves four distinct waiver populations:
FE, PD, TBI and IDD
MFP consumers can receive 365 days of service. Upon completion, they move seamlessly to the waiver services without going to the waiting list.

The member must meet the following criteria:
• Be a current resident of a nursing facility (NF) or intermediate care facility for mental retardation (ICF/MR) with a 90-day continuous stay – Medicare reimbursed days do not count
• Be Medicaid-eligible one day prior to receiving MFP services
• Meet the functional eligibility for waivered services
• Have an interest in transitioning back into the community
Money Follows the Person (MFP) continued...

Services offered under the MFP program include:

• Waiver services specific to the program to which the member will be enrolled

• Transition services – up to $2,500 to aid in the financial assistance needed to establish a household and necessary items within that household

• Home modifications

• Enhanced assistive services

• Transition coordination services- contracted by the MCO and paid for by the state; this can include finding housing
WORK
Age criteria 16-64 non-SSI recipient

The member must meet the following criteria:

• WORK is not a waiver program but is designed for individuals who are recipients of the PD, IDD, or TBI waivers or on the waiting lists for these waivers or demonstrates a need for a similar level of care as individuals on these waivers

• Have verified earned income which is subject to FICA/SECA taxes

• Earn a minimum of $65.01/month, if employed by an employer, or earn $85.01 a month, after employment related expenses are deducted

• Have earnings at or above the federal minimum wage (unless self-employed)
WORK
Age criteria 16-64 non-SSI recipient, continued...

Services offered under the WORK program include:
• Personal services (PAS)
• Independent living counseling (ILC)
• Assistive services
• Medicaid state plan services

No Harm Policy
• Members who were on a home and community-based services (HCBS) waiver before switching to WORK may return to the HCBS waiver without losing services.
• Consumers who were on an HCBS waiting list prior to WORK will maintain their place on the waiting list.
Member benefits and supports

- Pharmacy
- Transportation
- Value-added services
- Service coordination model
- Amerigroup On Call
- Disease management
- Interpreter services
- Member grievances and appeals

KanCare

Amerigroup Real Solutions in healthcare
Pharmacy program

The preferred drug list and formulary are available online.

Prior authorization is required for:

- Nonformulary drug requests
- Brand-name medications when generics are available
- High-cost injectable and specialty drugs
- Any other drugs identified in the formulary as needing prior authorization

*Note: This list is not all-inclusive and is subject to change.
Transportation

Access2Care is the transportation vendor for Kansas.

Contact Access2Care at 1-866-410-0002.
Value-added benefits

We offer a rich set of extra benefits to all eligible members:

<table>
<thead>
<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>Dental care for adults – two free cleanings per year</td>
</tr>
<tr>
<td>Free SafeLink® mobile phone with 350 free monthly minutes, plus 200 bonus lifetime minutes and unlimited texts*</td>
</tr>
<tr>
<td>Healthy Rewards program – $10, $15 or $25 debit card credits for over-the-counter items when you get certain health check-ups or screenings</td>
</tr>
<tr>
<td>Free stop-smoking program for adults</td>
</tr>
<tr>
<td>Weight Watchers® for adults who qualify</td>
</tr>
<tr>
<td>Free healthy living coaching for families with kids ages 7-13 who qualify</td>
</tr>
<tr>
<td>Up to $100 one-time credit for hypoallergenic bedding for people with allergies</td>
</tr>
</tbody>
</table>

*Coverage may not be offered in certain remote service areas. SafeLink Wireless® is a Lifeline-supported service. Lifeline is a government benefit program. Only those who qualify may enroll in Lifeline. It can’t be transferred. It is limited to one per household. You may need to show proof of income or that you take part in the program to enroll.
# Extra benefits for SSI and waiver members

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Extra over-the-counter medicines when using mail-order pharmacy</td>
<td></td>
</tr>
<tr>
<td>Free rides to community health events</td>
<td></td>
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<tr>
<td>Free nonemergent transportation to medical appointments is available to</td>
<td>members and their caregivers if the member resides outside of an institutional setting via Access2Care</td>
</tr>
<tr>
<td>members and their caregivers if the member resides outside of an</td>
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<tr>
<td>institutional setting via Access2Care</td>
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<tr>
<td>Up to $500 per year for in-home pest control for homeowners*</td>
<td></td>
</tr>
<tr>
<td>Extra respite care for Autism and Intellectual or Developmental</td>
<td>Disability</td>
</tr>
<tr>
<td>Disability waiver members*</td>
<td></td>
</tr>
<tr>
<td>Respite care for Frail Elderly waiver members*</td>
<td></td>
</tr>
<tr>
<td>Extra personal-assistant services for Intellectual or Developmental</td>
<td>Disability waiver members</td>
</tr>
<tr>
<td>Disability waiver members*</td>
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</tr>
</tbody>
</table>

*Based on calendar year. Excludes members residing in ICF/MR, assisted living and nursing facilities, group homes or similar settings.
Reassess and evaluate

- The service coordinator contacts the member and reassesses the member’s needs and functional capabilities.
- The service coordinator and member evaluate and revise the service plan as needed.

Service delivery

- The member selects providers from the network.
- The service coordinator works with care team to authorize and deliver services.
- The service coordinator ensures all appropriate services are authorized and delivered according to the service plan.

Identify needs

- The member is contacted and screened for complex needs and high-risk conditions.
- The service coordinator identifies the complex and high-risk member as needing a home visit.

Service plan

- The service coordinator makes a home visit and conducts a comprehensive assessment of all medical, behavioral, social and long-term care needs.
- The service coordinator works with team of experts to develop a service plan to meet the member’s needs.
- The service coordinator contacts the member’s PCP for concurrence.
- The member and his or her family review and sign the service plan.
Role of the provider

• Verifying member eligibility
• Obtaining precertification
• Coordinating benefits
• Notifying us
• Partnering with us
• Managing continuity of care
Service plans

• Member’s history
• Summary of current medical and social needs/concerns
• Short and long-term needs and goals
• Required services/frequency of services
• Who will provide services?
Amerigroup On Call
1-866-864-2544

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

• Find doctors when your office is closed, whether after hours or weekends
• Schedule appointments with you or other network doctors
• Get to urgent care centers or walk-in clinics
• Speak directly with a doctor or a member of the doctor’s staff to talk about their health care needs
Disease Management

The goal of Disease Management programs is to offer a combination of treatment, complication prevention and education in a variety of settings. We offer programs for members living with:

- Asthma
- Bipolar disorder
- Congestive heart failure
- COPD
- Diabetes
- HIV/AIDS
- Major depressive disorder
- Obesity
- Schizophrenia
- Substance use disorder
- Transplants
- And more
Interpretation services

- 24 hours a day
- 7 days a week
- Over 170 languages

Member Services: 1-800-600-4441
Provider Services: 1-800-454-3730
Member grievances and appeals

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

• When a provider indicates a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function, the member or provider may file an expedited appeal either orally or in writing

• Member Services: 1-800-600-4441 (TTY 711)
Provider responsibilities and actions

• Precertification and notification
• Critical incident reporting
• Electronic Visit Verification (EVV) system (assisted-living facilities are excluded)
• Claims submission process and options
• Coordination of benefits
• Electronic funds transfer options
• Grievances and appeals processes
• Ongoing credentialing
• Fraud, waste and abuse
• Cultural competency
Precertification and notification

Your provider manual and the website Precertification Lookup Tool list services requiring precertification and/or notification.
Critical incident reporting

Critical incidents include the following:

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

This link contains an explanation and directives on the reporting process:
kdads.ks.gov/docs/default-source/CSP/CSP-Documents/bhs-documents/air/attachment_a_csp_adverse_incident_definitions_and_protocol-(1).doc?sfvrsn=6
What is Electronic Visit Verification?

Electronic Visit Verification (EVV) is an automated system we use to monitor member receipt of certain waiver services.

EVV services are provided by Authenticare. Authenticare’s toll free provider line is 1-800-441-4667.
Functionality of the EVV system

- Log the arrival and departure of the provider/staff worker
- Verify services are being delivered in the correct location and at the appropriate time
- Verify the identity of the individual provider/staff worker providing the service
- Match services provided to a member with services authorized in plan of care
- Ensure the provider/staff worker delivering the service is authorized to deliver such services
Functionality of the EVV system, continued...

- Establish a schedule of services for each member
- Provide immediate notification to service coordinators and appropriate provider if a worker does not arrive as scheduled
- Log the meals a provider of home-delivered meals has delivered
- Submit claims to us
- Reconcile submitted claims with service authorizations
Options for submitting claims

- KanCare front-end: kmap-state-ks.us
- By mail: Amerigroup, P.O. Box 61010, Virginia Beach, VA 23466
- Web-based: Our website, Availity–availity.com or 837
  - Submit claims on our website by:
    - Entering claims on a preformatted CMS-1500 and CMS-1450/UB04 claim template
    - Uploading a HIPAA-compliant ANSI 837 5010 claim transaction
Options for submitting claims, continued

- Via clearinghouse – payer IDs are as follows:
  - Emdeon: 27514
  - Capario: 28804
  - Availity: 26375
- EVV system – authenticicare.com/kansas/login.aspx
Tips to prevent denied claims

• Use the correct Tax ID Number (TIN) for provider rendering services.
• Ensure you are contracted with and credentialed by Amerigroup for the services being rendered.
• Bill with entity name per your Amerigroup contract.
• If you submitted a National Provider Identifier (NPI) during credentialing, ensure you submit the same NPI on claims.
• Referring NPI is not required when billing for waiver services.
Tips to prevent denied claims, continued

- All waiver services require that an authorization is systematically available before a claim can be properly adjudicated by our examiners.
  - EVV mandated providers will review the availability of authorizations via the Authenticare system.
  - The Amerigroup self-service portal for providers encompasses a dashboard titled Patient 360°℠; this portal can be accessed by logging into providers.amerigroup.com/KS. Patient 360°℠ has the functionality to populate and list authorized services. It is best practice to check this dashboard prior to claims submission as this practice ensures that authorizations are available to our examiners during the adjudication process.
  - Please reference the internet service provider and contact the service coordinator of record if you have questions and concerns surrounding authorizations.

Patient 360° is a registered trademark of PatientPoint Network Solutions, LLC.
Tips to prevent denied claims, continued

• Questions? Call our Electronic Data Interchange department at 1-800-590-5745.
Corrected claims

• Corrected claims may be submitted via:
  o Paper: Claim should be marked as Corrected Claim and include the original claim number to Amerigroup Kansas, Inc., P.O. Box 61599, Virginia Beach, VA 23466-1599
  o Our website – Providers can submit corrections by using the resubmit option on Availity at availity.com
  o An approved clearinghouse

• Corrected claims must be submitted within the applicable timely filing limit and cannot contain correction fluid/tape or handwritten information
Corrected claims continued...

• Corrected claims must have the proper resubmission code of seven on the claim in order for our system to recognize that the claim is a correction to a previously processed claim.

• Explanation of common resubmission codes:
  o 5: Late charges only claim
  o 7: Correction/Replacement of prior claim
  o 8: Void/Cancel prior claim
Rejected vs. denied claims

If you get a notice that your claim was rejected or denied, here’s the difference.

**Rejected**
Does not enter the adjudication system due to missing or incorrect information

**Denied**
Goes through the adjudication process but is denied for payment
Routine claim inquiries

- Our Provider Experience program ensures provider claim inquiries are handled efficiently and in a timely manner
- Calls are handled by a specially trained call agent in Provider Services: 1-800-454-3730
Member billing

• Do not balance-bill members for any covered services under the KanCare program

• Monthly obligations are set by the state of Kansas and are the member’s responsibility to pay directly to the assigned and designated provider of record

• As of October 2015, the new code set ICD-10 will replace ICD-9. Please bill your HCBS claims utilizing diagnosis code R68.89.
Coordination of benefits

We will:

• Coordinate KanCare benefits with primary private insurance carriers/Medicare/third-party subrogation vendors

• Coordinate and collect monies directly from the these parties for services

• Accept crossover claims for coordination and payment of services for dually eligible members covered under traditional and managed Medicare plans
Electronic funds transfer

If you sign up for electronic remittance advice (ERA) or electronic funds transfer (EFT), you can:

• Start receiving ERAs and import the information directly into your patient management or patient accounting system
• Route EFTs to the bank account of your choice
• Create your own custom reports within your office
• Access reports 24 hours a day, 7 days a week

For more information, call Provider Services at 1-800-454-3730 or visit the following websites:
• Payspan - payspanhealth.com
• Emdeon - emdeon.com/epayment
Payment appeals

• Use Clear Claim Connection for guidance when you submit a claim.
• Submit payment appeals online at https://providers.amerigroup.com/KS.
• Submit all payment appeals with a copy of the Explanation of Payment, supporting documentation and a letter of explanation.
Provider grievances

We track all provider grievances until they are resolved. You may file grievances to us by phone, by fax or in writing. The provider manual details filing and escalation processes and contact information.

Provider Services: 1-800-454-3730, fax: 1-866-494-5632
Amerigroup Kansas, Inc.
Attn: Provider Relations-Provider Grievance
9225 Indian Creek Parkway, Building 32
Overland Park, KS 66210
Medical appeals

• Separate and distinct appeal processes are in place for our members and providers, depending on the services denied or terminated.
• Please refer to the denial letter issued to determine the correct appeals process.
Ongoing credentialing

Recredentialing occurs every three years or sooner if required by state law.

Please notify your provider consultant or email providers services at ks1provrel@amerigroup.com if you have any changes in licensure, demographics, services or participation status.
Fraud, waste and abuse

Help us prevent it, and tell us if you suspect it.

- Verify patient’s identity
- Ensure services are medically necessary
- Document medical records completely
- Bill accurately
Cultural competency

We expect our providers and their staff to gain and continually increase in knowledge, skill and improved attitudes about and sensitivities to diverse cultures.

This results in effective care and services for all people by taking into account each person’s values, reality conditions and linguistic needs.
Provider resources

Provider website: https://providers.amerigroup.com/ks

- Registration and tutorials
- How to verify eligibility
- How to use our Precertification Lookup tool
- Submitting precertification requests online
- How to check status of precertification request
- Submitting claims electronically
- How to check claims status
- How to file claims payment appeals
- On-site visits and training by provider consultants
- Key contact information
The provider website is available to all providers, regardless of participation status.

The tools on the site allow you to perform key transactions.
Web tutorials

Provider Education

Provider Updates and Other Communications

Manual

Miscellaneous

Pharmacy

Quick Reference Card

Tutorials and Training

Avality Frequently Asked Questions
Avality Site Guide
Claim Denials Presentation
Claims Appeal Tutorial
C15HC Provider Update Call
General Provider Orientation
HCBS Provider Update Call
HCBS Provider Update Call 2016
HRA Lookup Tool
Medication Precertification Tutorial
Member Information and Panel Listing
Orientation Feedback
Provider Orientation Schedule 2015
Provider Updates - Account Information
Training Verification Form
Website registration

We encourage providers to register to use the secure content on our website.

We offer online tutorials and user guides on the site to help you navigate.
Getting started is as easy as 1-2-3

Register online
Go to availity.com and click *Get Started* to complete the online registration wizard.
To expedite the registration process, have your Primary Controlling Authority (PCA), a person who is authorized to sign on behalf of your organization, complete the registration wizard.
From *My Payer Portal*, users are able to link to the Amerigroup provider self-service website.
Eligibility and benefits

Select the payer to which you are submitting the transaction; you can access eligibility and benefit information for any member.

*Add to Batch* allows you to inquire about multiple patients from multiple payers in one batch submission.

The service type description box lists the benefit details included for the selected benefit/service.
Is precertification required?

Our Precertification Lookup tool lets you search by market, member’s product and CPT code.
Precertification requests/status

Submit precertification requests through our provider website, by fax or by calling Provider Services:
• https://providers.amerigroup.com/KS
• 1-800-454-3730
• Fax: 1-800-964-3627

You can also check the status of your precertification request on our website or by contacting Provider Services to speak with an agent.
Claim status inquiry results

✓ Run eligibility and benefits first, then transfer to claims status inquiry. Patient/member information persists from one inquiry to another.
Key contact information

- Website address: providers.amerigroup.com/KS
- Provider Services/Provider Inquiry Line (IVR): 1-800-454-3730
  - Check eligibility, claims status and request precertification
  - Help with member missed appointments
- Precertification fax number: 1-800-964-3627
- Case management: 1-800-454-3730
- AT&T TTY service: 711
- Amerigroup On Call: 1-866-864-2544
  (Spanish 1-866-864-2545)
- Member Services: 1-800-600-4441
- Behavioral health services: 1-800-454-3730
- Behavioral health fax: 1-800-505-1193
- Scion Dental: 1-855-812-9206
- Access2Care: 1-866-410-0002
- Ocular Benefits: 1-866-416-0150
- AIM Specialty Health: 1-800-714-0040
Your Provider Relations representative

When you have questions, contact your Provider Relations representative. Request a business card today or reference the following link:
https://providers.amerigroup.com/ProviderDocuments/KSKS_ProviderReps.pdf
Next steps

• Register to use our provider website
• Register for electronic data interchange
• Register for electronic funds transfer services
• Read your provider manual
Thank you for partnering with Amerigroup RealSolutions in healthcare.