Medicaid New Provider Orientation

2026

KDHE Approved 01/16/2026

Agenda

- Who We Are
- Provider Data
- Ongoing Training Opportunities
- Website Resources
- All About the Member
- Prior Authorizations
- Billing for Your Services
- Secure Provider Portal
- Quality
- Finding Support

Who We Are

Our Purpose

- Transforming the health of the communities we serve, one person at a time.

Our Approach

- Sunflower strives to provide improved health status, successful outcomes, and member and provider satisfaction in an environment focused on coordination of care.



Who We Are

Our Mission

- Ensure access to primary and preventive care services in accordance with the Kansas Department of Health and Environment - DHCF and KDADS standards;
- Ensure care is delivered in the best setting to achieve optimal outcomes;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical care;
- Provide medical coverage in a cost-effective manner

Recommendations

- Ask if the patient is receiving services elsewhere;
- Reach out to those other providers of care;
- Discuss test results and follow-up actions with the patient;
- Document all discussion topics in the patient's medical record, sign & date at the time of service – If it isn't documented, it didn't happen.

Who We Are

Lines of Business

KanCare
Kansas Medicaid

Wellcare
Medicare plans

Ambetter - Marketplace
(Affordable Care Act)

Organizational Structure

- **Care Management**
- **Medical Management**
- **Claims**
- **Network**
- **Provider Relations**

Social Determinants of Health

What does “social determinants of health” mean?

- Conditions of the environments in which people live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Goal of “social determinants of health.”

- Create social and physical environments that promote good health for all.

Employment

Housing

Food Insecurity

Social Integration

Provider-Member Communication

Why is communication important?

- Affects patients' perception of the care they are receiving.

Why could a patient not understand what their healthcare provider is telling them?

- The patient's social and/or economic status
- The patient's education level
- The complexity of the treatment and instructions
- Health system variables

Here are some ways to encourage better communication with patients:

- Build rapport with the patient
- Do not interrupt the patient
- Ask open-ended questions
- Empower the patient

KMAP Provider Enrollment

History

- December 2018 the KMAP Provider Enrollment Wizard became available for use.
- July 2019 KMAP Provider Enrollment now required for Sunflower to pay claims to providers for Medicaid services, including the TIN, NPI, type and specialty.
- For additional information go to KMAP Provider Enrollment

Medicaid Credentialing and Contracting Details

- Initial enrollment is completed on the KMAP Provider Enrollment Wizard.
- Approved KMAP Provider Enrollment is forwarded to Sunflower if selected in the application submitted.
- Upon receipt of approved KMAP Provider Enrollment, Sunflower begins to complete necessary contracting (50 days) and/or credentialing (45 days) steps, including applicable provider data loading (7 days).
- Contracting, credentialing and system loading with Sunflower must be completed before provider claims will successfully process and pay to the provider.
- All Medicaid providers are subject to recredentialing every three years.

To check on the status or ask questions regarding credentialing or contracting please email sunflowerstatehealth@centene.com.

Provider Enrollment Updates

- KMAP is the Kansas Medicaid provider source of truth.
- Demographic updates, provider changes and revalidation follow applicable KMAP provider instructions, i.e., bulletins, manuals. Begin the process at KMAP Provider Enrollment
- Providers should direct all changes to their provider record to KMAP. Updates are sent to the Managed Care Organizations from KMAP. This includes practitioners leaving or joining the practice.
- For more information, please view KMAP Bulletins page using keyword ‘enrollment’ or ‘revalidation’.

K-TRACS Pharmacy Reporting

Medicaid providers must check the **Kansas Prescription Drug Monitoring Program (called K-TRACS)** for an enrollee's prescription history before prescribing controlled substances to a Medicaid beneficiary or member.

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions. Information from PDMPs can help clinicians identify patients who may be at risk for overdose and provide potentially life-saving information and interventions.

K-TRACS Login

When does a provider have to check K-TRACS:

- New patient visit: Check K-TRACS prior to writing/e-scribing a controlled substance.
- Current patient visit: Recheck K-TRACS every 180 days or when there are any changes to the patient's controlled substance prescriptions.
- Prescribers may not be required to check K-TRACS for all beneficiaries/members. All exceptions can be found in the 2024 Sunflower Provider Bulletin at Sunflower K-TRACS Pharmacy Reporting Bulletin.

Annual Attestation

- Every provider must submit an annual attestation form by January 1st of each year acknowledging their awareness of and compliance with our PDMP policies. The State and MCO will post reminder bulletins on their websites.
- Should a provider not submit an attestation form that acknowledges said compliance with PDMP policies, by the annual due date, this will be considered as provider non-compliance.

HCBS Background Check Publications

4/29/2025 - **KDADS Standard Policy** - HCBS Background Check Policy, E2025-033

This policy outlines the processes and procedures for conducting HCBS background checks. It also defines the procedures for HCBS providers offering provisional employment and details the flexibilities permitted for Self-Directing HCBS waiver participants regarding HCBS background checks.

4/30/2025 – **HCBS Background Check Policy** KMAP General Bulletin 25091

Effective retroactively to April 1, 2025, the Kansas Department for Aging and Disability Services (KDADS) has updated the Home and Community-Based Services (HCBS) background check policy to clarify the processes and procedures for conducting background checks.

HCBS Provider Qualification Audit Publications

12/22/2025 – **2026 HCBS Provider Qualifications Audit** – KMAP General Bulletin 25299

- Per Kansas Medical Assistance Program (KMAP), the State has delegated auditing of Home and Community Based Services (HCBS) provider qualifications to the Managed Care Organizations (MCOs).

1/5/2026 – **2026 HCBS Provider Qualifications Audit Process-Updates and Information** – KMAP General Bulletin 25321

- A full audit was implemented in 2024, and this will continue. From 2020-2023, a limited audit was conducted focusing on general provider qualifications (staff background checks, Community Developmental Disability Organization [CDDO] affiliation agreements, Community Mental Health Centers [CMHC] license).

Fraud, Waste & Abuse (FWA)

Some of the most common FWA practices include:

- Unbundling of codes
- Upcoding services
- Add-on codes billed without primary CPT
- Claims for services not rendered
- Use of exclusion codes
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Excessive use of units
- Misuse of benefits

Ways to Report Potential Fraud, Waste and Abuse

- Call the **Sunflower FWA Hotline** at 1-866-685-8664. You do not need to give your name.
- Contact Sunflower at Sunflower Health Plan Program Integrity, 8325 Lenexa Dr., Ste 410, Lenexa, KS 66214.
- You can also report suspected provider fraud, waste and abuse to the Kansas Medicaid Fraud and Abuse Division. Contact Kansas Attorney General's Office Medicaid Fraud & Abuse Division - 120 SW 10th Ave., 2nd Floor, Topeka, KS 66612-1597 Phone: 866-551-6328 or 785-296-5050.
  - Complaints also may be submitted online at KS Medicaid Fraud & Abuse

Cultural Competency

Our commitment

- Providing quality health care services regardless of race, color, national origin, sex, sexual orientation, gender identity, age, or disability.
- Developing, strengthening, and sustaining healthy provider/member relationships.

Our plan

- Our staff complete annual Cultural Competency and sensitivity training.
- Offer information, resources and quarterly training to our providers.
- For additional information and resources on Sunflower's Cultural Competency program webpage.

Annual Cultural Competency Training Requirements

- Verification of Cultural Competency Training
- Why? We are required to collect information on whether providers have completed Cultural Competency training and to display that in our provider directory and Find a Provider tool.
- What are the training requirement options? Choose one of the following:

	Sunflower	HHS	Continuing Education	Organizational Training
	Offered On Demand Bi-monthly Live Sessions	Complete HHS Think Cultural Health online session	Complete continuing education on cultural competency	If the provider organization offers in house cultural competency training
Resources	Sunflower Cultural Competency Training	HHS Cultural Competency Training		
Verification	Submit Verification of Completed training via WebForm: Training Attestation Form			

Provider Training

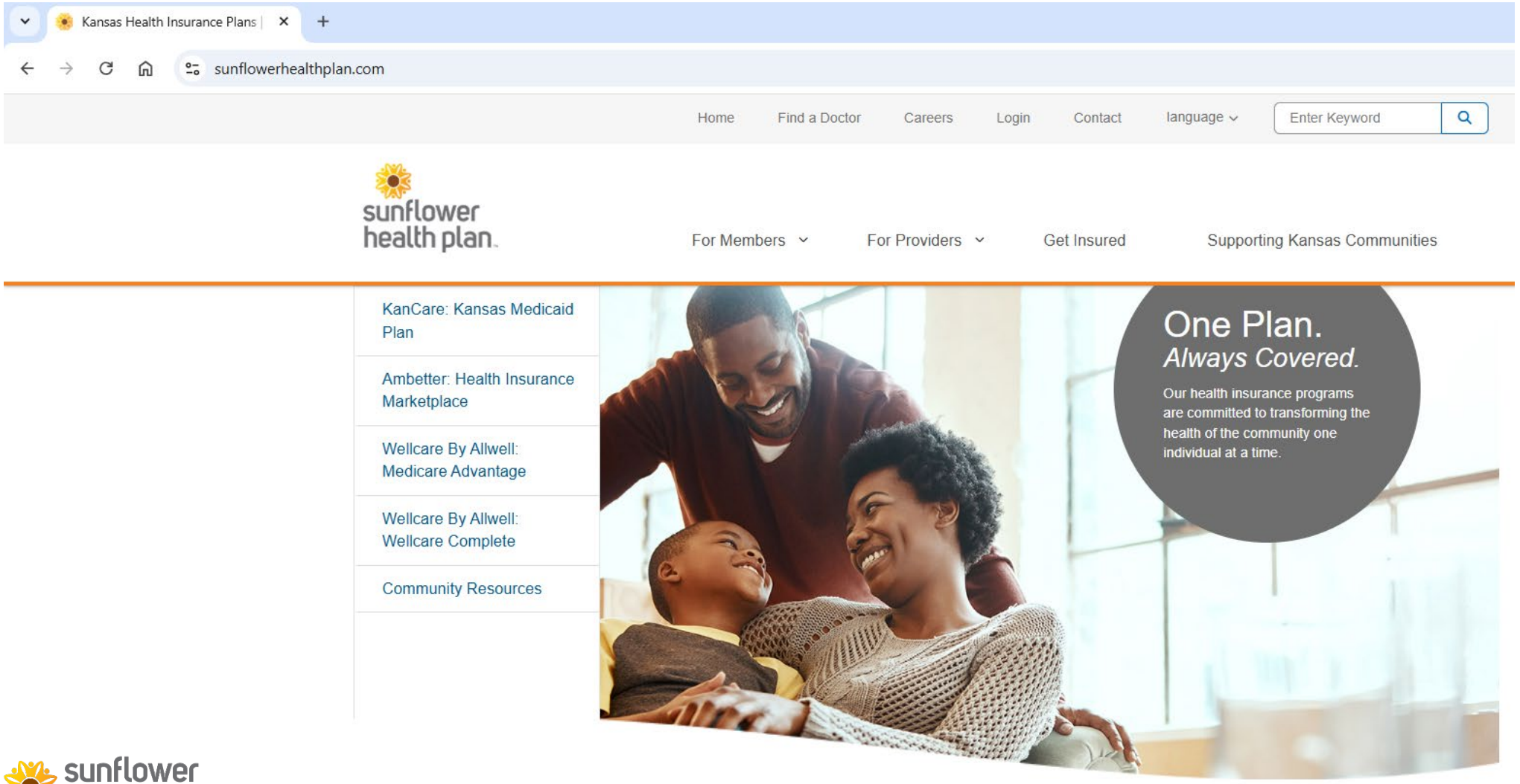
Project ECHO (Sunflower Project ECHO webpage):

- Project ECHO® (Extension for Community Healthcare Outcomes) is a self-paced lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities.
- Quarterly Topics
- Free Continuing Education credits for licensed clinicians through the University of Missouri and certificate of completion for social workers & therapists.

Provider Office Hours

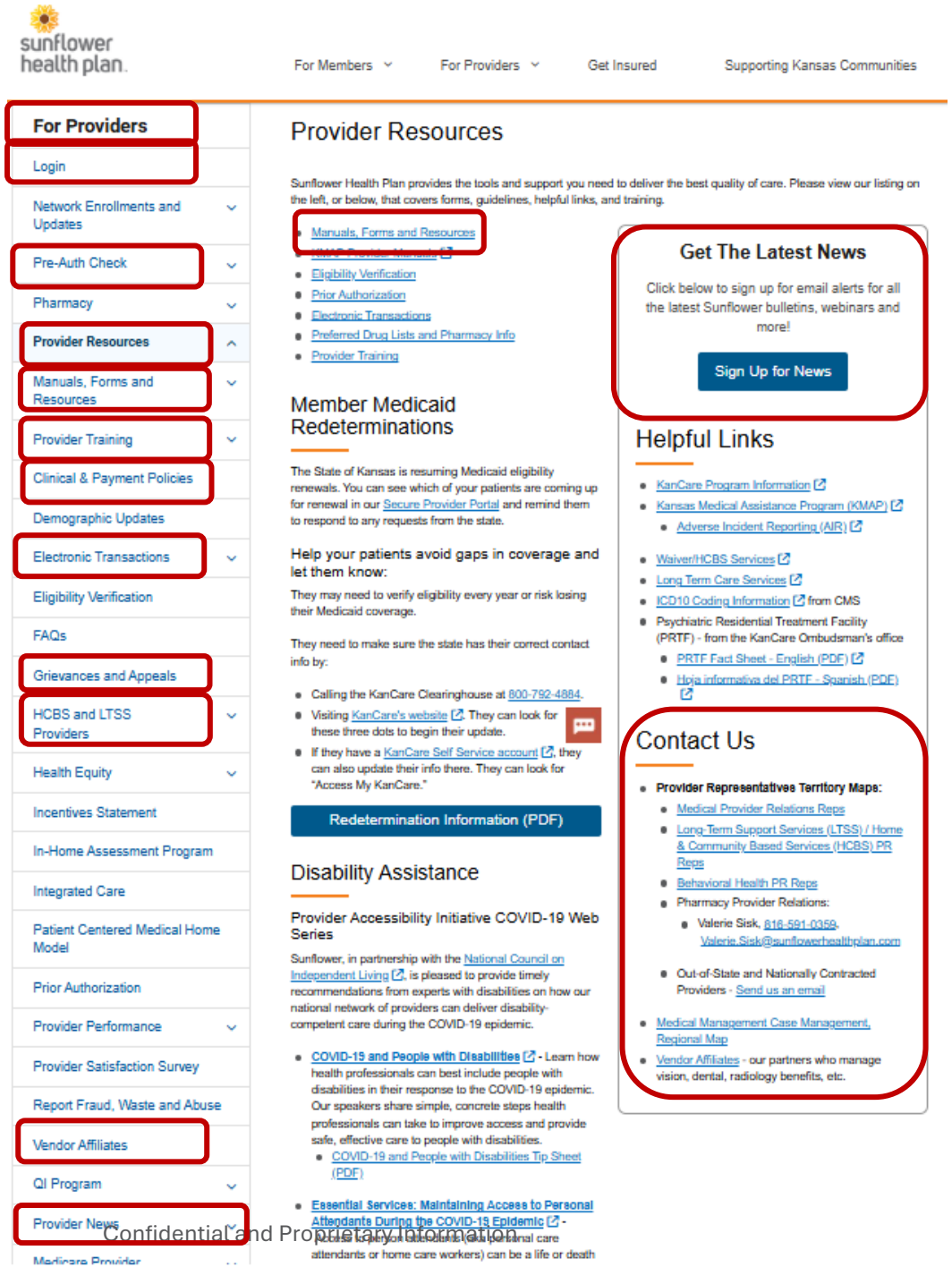
- Guidance on navigating the KMAP website or Sunflower website, how to reach Provider Relations, how to navigate the Secure Provider Portal and more. Registration is not required. See our Sunflower Provider Training webpage for session dates, additional training opportunities and upcoming events

Our Website: SunflowerHealthPlan.com



Kansas Health Insurance Plans from Sunflower Health Plan

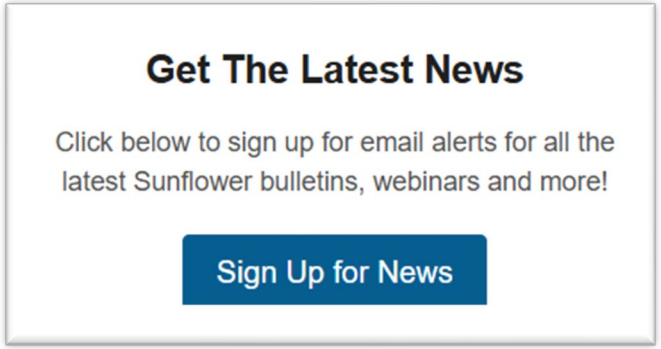
Provider Resources

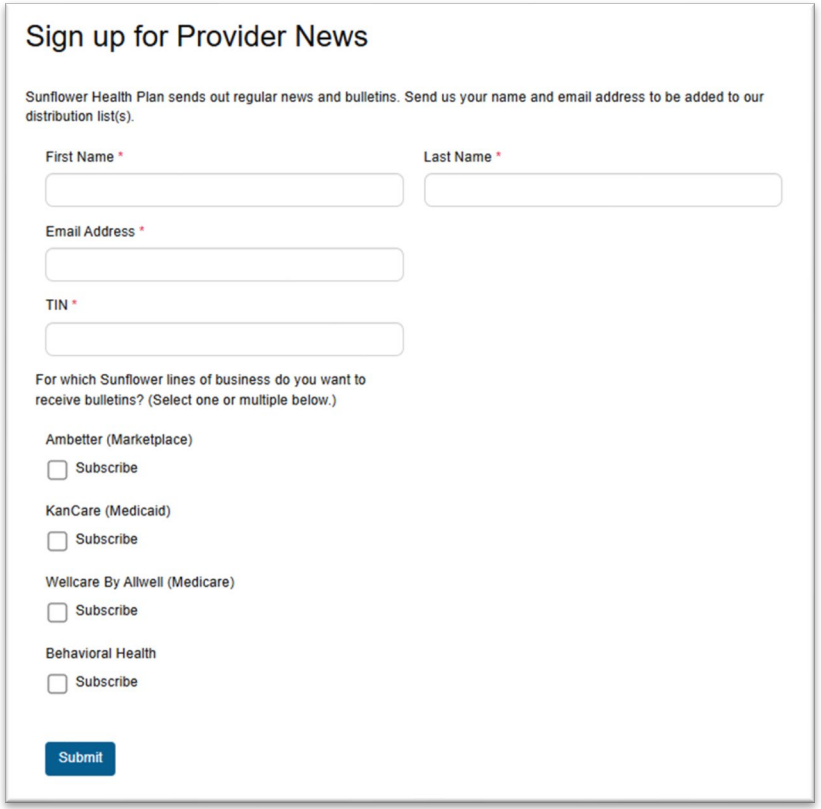


Sign Up Provider Bulletins

Sign up for Provider Bulletins:

- State and Health Plan Policy Changes
- Training Webinars
- Holiday Check Run Updates





Appointment Availability & Access Standards

PRIMARY CARE & PEDIATRIC
- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 21 calendar days of request

SPECIALIST
- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 30 calendar days

OBGYN
- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 15 business days of request
- **First Trimester**: Within 3 weeks
- **Second Trimester**: Within 2 weeks
- **Third Trimester**: Within 1 week

Wait Time Standards for All Provider Types

- Office waiting time for scheduled appointments not to exceed 45 minutes. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

SUBSTANCE USE DISORDER (SUD)
- **Urgent Substance Use Disorder:** Assessed within 24 hours of request; services delivered within 24 hours of the assessment.
- **Routine SUD:** Assessed within 10 business days of the request.
- **Pregnant and Person who Injects Drugs (PWID):** Provide services within 24 hours of assessment or 48 hours of initial contact to include prenatal care.
- **Person who Injects Drugs (PWID):** Assessment and admitted to treatment no later than 10 business days of request.

BEHAVIORAL HEALTH
- **Non-Life-Threatening Behavioral Health Emergency:** Within 6 hours
- **Urgent:** Within 72 hours
- **Routine Outpatient (Initial Assessment or Follow-Up):** Within 10 business days

24-Hour Access to Providers

Members must be able to access their providers 24-hours a day, 365 days a year
- Provider's office phones must be answered during normal business hours
- Message left during normal business hours should be returned the same day

Members must be able to access their provider after normal business hours and on weekends by either
- Answering service or system that will page physician
- Answering system with option to page physician
- Advice nurse with access to physician
- Answering service that will page the physician after message is left
- Answering system provides phone number to access physician live or answering service

Unacceptable after-hours coverage include, but not limited to:
- A recording telling callers to leave a message
- A recording telling callers to go to an emergency department
- Calls not returned within 30 minutes

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits. It is recommended to record the message banner in English and Spanish. All pre-recorded messages must be high-quality, informative, and provide callers with certainty that they have reached the practice whose number they dialed. A member should, at minimum, have a means for leaving a message and should be told when to expect a return call.

Clinical and Payment Policies

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Health care claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding.

Clinical Policies

Medicaid Clinical Policies

Policy Number	Policy Title
CP.MP.92	Acupuncture (PDF)
CP.MP.124	ADHD Assessment and Treatment (PDF)
CPG Grid	Adopted Clinical Practice and Preventive Health Guidelines (PDF)

Medicaid Behavioral Health Clinical Policies

Policy Number	Policy Title
CP.BH.104	Applied Behavior Analysis (PDF)
CP.BH.105	Applied Behavioral Analysis Documentation Requirements (PDF)
CP.BH.500	Behavioral Health Treatment Documentation Requirements (PDF)

Notice of Admissions

Admissions, Census Reports or Face Sheets should be reported by calling 1-877-644-4623 or by fax to 1-866-965-5433

Hospitals should:

- Notify the member's PCP immediately or no later than the close of the next business day after the member's emergency room visit.

Notify Sunflower's Population Health Department of:

- All inpatient admissions within one business day following the admission. Clinical information must be submitted with the admission to support medical necessity criteria.
- Discharge dispositions or additional documentation on admissions where Sunflower may not be the primary payer.
- All admissions via the ER within one business day.
- All newborn deliveries within one day of the delivery.

Member ID Card

KanCare | sunflower health plan

Pharmacy:
RXBIN: 003858
RXPCN: MA
RXGROUP: 2ELA

NAME:

#: DOB:

PCP Name:

PCP Phone:

Effective Date: Copay: $0

If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your PCP or Sunflower's 24/7 nurse line at 877-644-4623 (TTY 711).

8325 Lenexa Drive, Suite 410, Lenexa, KS 66214
www.SunflowerHealthPlan.com

IMPORTANT CONTACT INFORMATION

Members:
Customer Service: 877-644-4623
(TTY 711)
Transportation: 877-917-8162
Vision: 877-644-4623
Dental: 877-644-4623
Behavioral Health: 877-644-4623
Pharmacy: 877-644-4623

Providers:
Provider Services & IVR Eligibility Inquiry
- Prior Auth: 877-644-4623
Pharmacists Only: 833-750-4447

EDI/EFT/ERA please visit
For Providers at
www.SunflowerHealthPlan.com

Medical Correspondence/
Non-Claims:
Sunflower Health Plan
PO Box 4070
Farmington, MO 63640-3833

Behavioral Correspondence/
Non-Claims:
Sunflower Health Plan
PO Box 6400
Farmington, MO 63640-3807

Provider Claims information via the web: www.SunflowerHealthPlan.com

Verifying Member Eligibility

When to verify?

- When scheduling an appointment for a Sunflower member.
- When a Sunflower member is seen for an appointment.

How to verify?

- KMAP Secure Website
- Sunflower Provider Portal
- Availity Essentials
- Customer service & Interactive Voice Response (IVR)
  1-877-644-4623 (TTY 711)

Possession of an ID card is not a guarantee of eligibility and benefits.

PCP Selection

- Each new member is assigned a primary care provider (PCP) once they are enrolled with Sunflower Health Plan.
- Members may change their PCP at any time through our member portal, by calling Customer Service or by returning a completed PCP change form located on our website.
- Members do not need a referral before seeing another network physician or specialist.

What is a Grievance?

A grievance is defined as any expression of dissatisfaction about any matter, other than an adverse benefit determination or an action that would be resolved through the appeals process.

- Providers have 180 calendar days to request a grievance from the date of the matter being grieved.

Grievances may include, but are not limited to:

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights
- Access to care – unable to get an appointment
- Quality of care – no prescription given at appointment and member ended up in ER
- Attitude or service, Health Plan – rudeness of plan staff to member
- Attitude or service, Provider – provider rudeness
- Quality of practitioner office site – provider office is dirty

For more information regarding filing a grievance, please see the Sunflower Provider Manual.

What is a Member Appeal?

- An appeal is a request for review of an adverse benefit determination
- An adverse benefit determination is the denial or limited authorization of a requested service, which can include any of the following:
  - The denial or limited authorization of a requested service, including the type or level of service
  - The reduction, suspension, or termination of a previously authorized service
  - The denial, in whole or part of payment for a service
  - The failure to provide services in a timely manner
  - The failure of plan to act within the timeframes to resolve grievances and appeals
  - For a member residing in a rural area with only one MCO, the denial of member's request to obtain services outside the network
  - The denial of member's request to dispute a financial liability
- Report to any health plan employee is valid and starts process
- For more information regarding filing an appeal, please see the Sunflower Provider Manual.

2026 Value Added Benefits for Members

Benefit	Description
Enhanced Transportation Benefits	Twelve roundtrips per year for things like food, housing, pharmacy, employment supports, support groups or health-education programs.
Car Seats	Members in our Start Smart for Your Baby program can get a safety-certified car seat or booster seat for getting regular checkups and screenings that support a healthy pregnancy.
First Year of Life	Educational materials and support from maternal/childcare coordinators to schedule well-child visits and access resources. (Ages 0-15 months.)
Pyx Health	Pyx is a mobile application tool used to reduce loneliness using an empathetic chatbot, Pyxir, and is open to all members
My Health Pays® Rewards	Members rewarded for certain health-plan identified activities like $10 for completing a yearly health information form. (Updated activities and dollar amounts. Rewards can be spent at Hy-Vee and Walmart.)
Cell Phones	Sunflower supports members through our relationship with Lifeline (federal program) providers, like Assurance, that provide voice, data, and text services for those who qualify. Assurance and SafeLink calls made to Sunflower Health Plan's toll-free number do not deplete available minutes.

2026 Value Added Benefits for Members

Benefit	Description
Start Smart® for Your Baby	Program for pregnant members, babies and their families. Start Smart features no-cost nursing support, education and gifts.
Community Programs for Children	• $50 credit per year for youth programs (Ages 5-18) • Sunny's Kids Club (Ages 0-12) • Strong Youth Strong Communities Program™ (SYSC).
Teladoc Digital Mental Health	An eLearning resource for well-being and mental health.
Farmers' Market Vouchers	$10 vouchers to spend at participating farmers markets.
Healthy Solutions for Life	Healthy Solutions for Life offers multiple health coaching programs.
Caregiving Collaborations®	Caregivers are supported through various channels in the Caregiving Collaborations program. This benefit is available to one primary, informal support caregiver per member.
Employment Support & Transportation	GROW (GED, Rides, Opportunities, Work) is an employment support resource program.

2026 Value Added Benefits for Members

Benefit	Description
Respite Care (FE & PD Waivers)	Up to 60 hours of respite care per year for non-paid caregivers.
Transition Services	Welcome Home Program helps members leaving jail or nursing facilities (who are not receiving other transition supports) to return home.
Peer Support Program	In-person and virtual training for waiver members.
Hospital Companionship	Up to 16 hours of hospital companionship.
Behavioral Health and Foster Care Training & Support Programs	Peer-support calls for foster & adoptive families. Training resources for families and providers.

Value-Added Benefits for Members on Waivers and Other Special Groups	
Practice Dental Visits (I/DD)	Up to two practice dental visits through member's dental provider's office.
Healthy Living (Harvey County)	Diabetes education classes for members living in Harvey County, KS.
Traditional Healing (American Indian & Alaska Native/AIAN)	Up to $200 per year for holistic treatments performed by traditional healing practitioners for American Indian and Alaska Native (AIAN) members.

Member Assistance

- **Non-emergent Medical Transportation (NEMT)** is available to members when they do not have a way to get to their medical or behavioral health appointments. To schedule transportation, call three days before the appointment SafeRide 1-877-917-8162.
- Centauri Health Solutions can help members apply for **Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)** if criteria is met.

Interpreter Services

- We offer access to interpreters for members who do not speak English or do not feel comfortable speaking it. It is important that our providers and members can talk about medical and behavioral health concerns in a way both can understand.
- Our interpreter services are provided at no cost and is available for many different languages including sign language. For members that are blind or visually impaired we will provide an oral interpretation.
- To arrange interpreter services, call Customer Service at 1-877-644-4623, TTY 711.

Sunflower Value Added Benefits

Care Coordination

- Care coordination involves deliberately organizing patient care activities and sharing information among all the participants (providers) concerned with a patient's care to achieve safer and more effective care.
- The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care.

Improved health outcomes.

Care Coordination

The Sunflower case management/care coordination program is designed to help members obtain needed services. Focusing on the whole person by partnering with our trusted providers to ensure members receive the right services, in the right place, at the right time. These services are implemented through:

- Care Coordination
- Complex / Intensive Case Management
- Disease Management

Some of the benefits of care management are:

- Working with members to develop a care plan
- Speaking with members at scheduled times
- Interacting with members doctors'
- Helping connect members with community programs and services
- Coordination and assistance with appointment scheduling

Providers can refer members for care management

  - Customer Service 1-877-644-4623
  - Secure Provider Portal

Care Coordination

How can providers facilitate Coordination of Care?

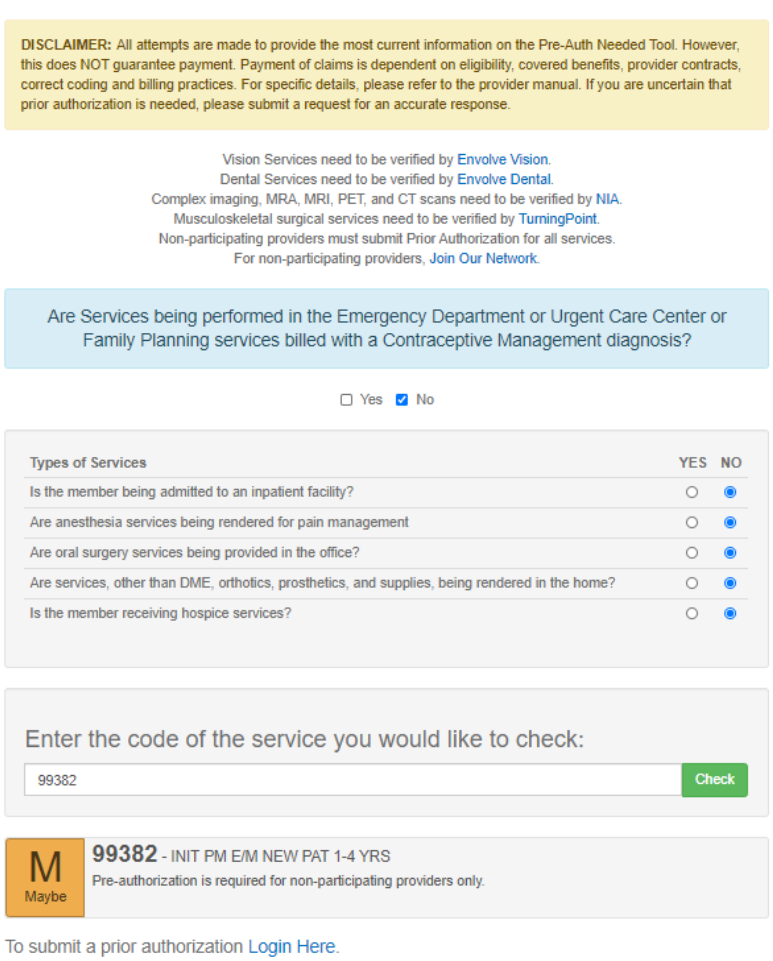
- By making referrals and following up on those referrals to other healthcare providers.
- Talking with members about the healthcare services they are receiving.
- Establish a communication plan with the member and other healthcare providers which may include obtaining signed releases by the member.
- Documenting the communication of services being provided by other healthcare providers in the medical record including the initiation of services, ongoing and completion of the services.

Advance Directives

- An advance directive is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.
- A living will allow individuals to document their wishes concerning medical treatments at the end of life.
- A medical power of attorney (or healthcare proxy) allows an individual to appoint a person they trust as a healthcare agent (or surrogate decision maker), who is authorized to make medical decisions on their behalf. Before a medical power of attorney goes into effect a person's physician must conclude that they are unable to make their own medical decisions.
- Refer to www.sunflowerhealthplan.com for additional details regarding Advance Directives.

Prior Authorization

Pre-Auth Check Tool



How to request Prior-Auth

- Complete Prior-Auth request on Secure Provider Portal
- Call Customer Service to request 1-877-644-4623 (TTY 711)
- Submit completed Prior-Auth fax forms

Vendor Affiliates

- Outpatient Therapy (PT, OT, ST)
- Radiology (i.e.., CT, PET, MRI)
- Musculoskeletal surgical services
- Oncology

State Systems

- Some HCBS services use AuthentiCare/Electronic Visit Verification

Medicaid Prior Authorization Examples

See the Forms section for Medicaid Prior Authorization Forms. **These examples are to serve as possible explanations. Providers should check the Pre-Auth Needed Tool as requirements may change.

Vendor Affiliates

Centene Vision Services
1-877-865-1834
www.envolvevision.com

Express Scripts
1-877-644-4623
www.sunflowerhealthplan.com/providers/pharmacy.html

CoverMyMeds for Prior Authorizations
1-866-452-5017
www.covermymeds.com

Radiology – Evolent
1-877-644-4623
www.RadMD.com

Centene Dental Services
1-855-434-9245
www.envolvedental.com

Musculoskeletal Surgical Svcs - Evolent
1-877-644-4623
www.RadMD.com

Oncology & medication – members > 21 - **Evolent**
1-888-999-7713 | my.newcenturyhealth.com/

Outpatient Therapy (PT) – Evolent
1-877-644-4623
www.RadMD.com

For additional details go to www.sunflowerhealthplan.com/providers/resources/vendors.html

Prior Authorization Reminders

- Submit all necessary clinical information when requesting an authorization. Failure to do so could result in a denial of authorization.
- Request authorization timely or the request will result in a denial for late notification.
- If a service requires prior authorization and an authorization is not obtained, if a claim is submitted the claim will deny for no authorization.
- When a member obtains eligibility retroactively follow the process outlined in the provider manual for retro-eligibility to request authorization and the impact of claims.
- Submit attachments in PDF format.

Prior Authorization Reminders

- Prior Authorizations can be requested by phone, fax, Sunflower Provider Portal or Availity Essentials.
- Prior Authorization approvals are NOT a guarantee of payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.
- Authorization status can be viewed on the Provider Portal (Sunflower or Availity).
- When a service is approved, a notice of approval is sent to the provider(s).
- When a service is denied, a Notice of Adverse Benefit Determination or Authorization Denial is sent to the member, and the provider(s).

Prior Authorization Denial

Notice of Adverse Benefit Determination (NABD)

- Providers are sent the NABD when a service is denied.
- Providers, on behalf of a member and with the member's written consent, may appeal the decision.
- Follow the steps outlined in the NABD regarding timeline to submit, how to submit, where to submit an appeal to a denial.

Medicaid Prior Authorization Requests

- When a member obtains eligibility retroactively, follow the process outlined in the provider manual for retro-eligibility to request authorization and the impact of claims. Provider Bulletin: Retro-eligibility Notification Process Update

Medical Necessity Criteria

Sunflower utilizes a variety of resources to determine medical necessity.

- State Medicaid Policies
- KMAP Provider Manuals
- Health Plan Provider Manuals – Medicaid
- Health Plan Clinical and Payment Policies
- One Healthcare ID
- Interqual
- American Society of Addiction Medicine

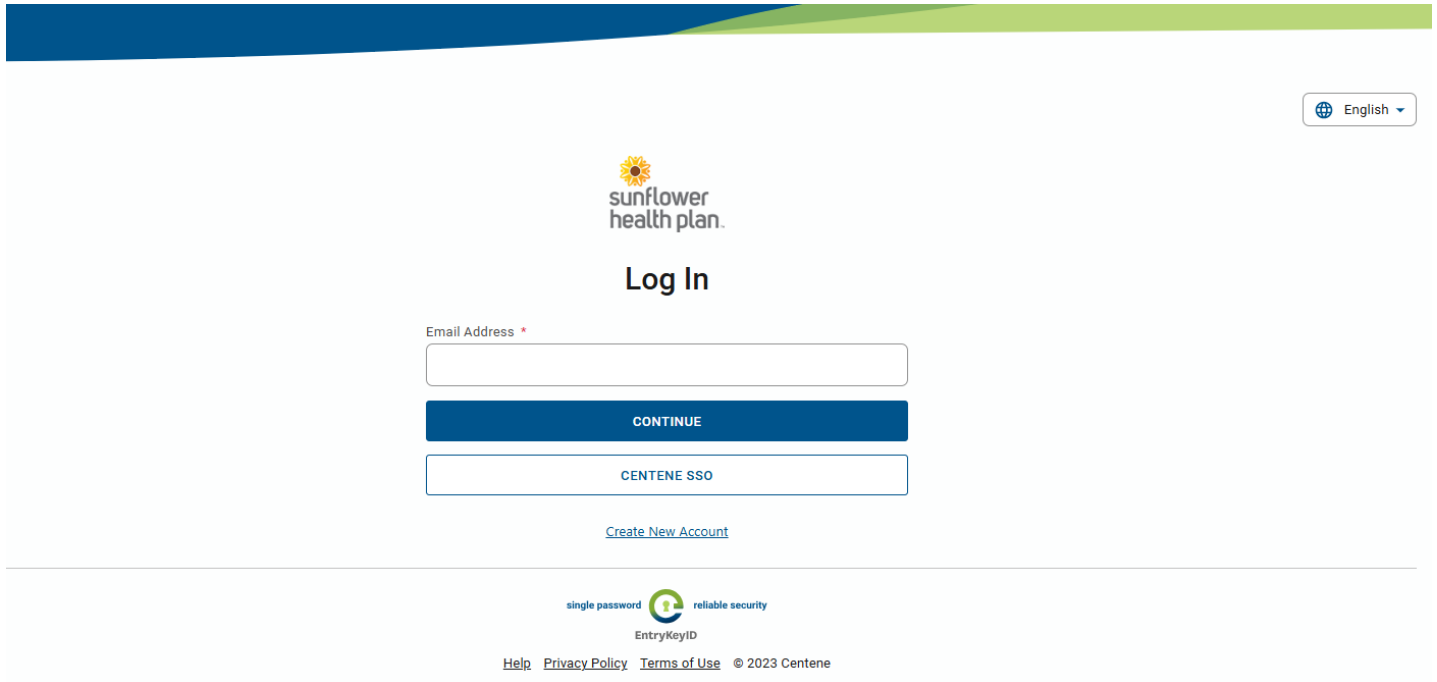
Prior Authorization Timelines

Type of Services		Provider Timeframe Request	Authorization Determination Timelines
Outpatient	Procedures, testing or interventions, home care services, hospice, genetic testing, pain management, DME, behavioral health	Request at least **5** business days before the scheduled service delivery date or as soon as the need for service is identified, keeping in mind a **7**-day turnaround time.	For standard prior authorizations, the decision and notification will be made within **7** calendar days from receipt of the request. For expedited prior authorization requests or concurrent IP requests, a decision and notification is made within **72** hours of the receipt.
Inpatient	Hospital stays, skilled nursing facilities, LTAC, acute rehab, sub-acute, swing bed	ALL inpatient admission require notification within one business day (by 5 p.m. CT) following date of admission.	
PRTF	Psychiatric Residential Treatment Facility	Guardian must request PRTF services for the child from the MCO. The MCO can then request a preauthorization review (PAR) and/or Community Based Services Team review (CBST review). The provider has seven days from the date of MCO request to return the clinical information to the MCO.	The MCO has **14** calendar days from the date the guardian requested PRTF services to make a Medical Necessity decision.

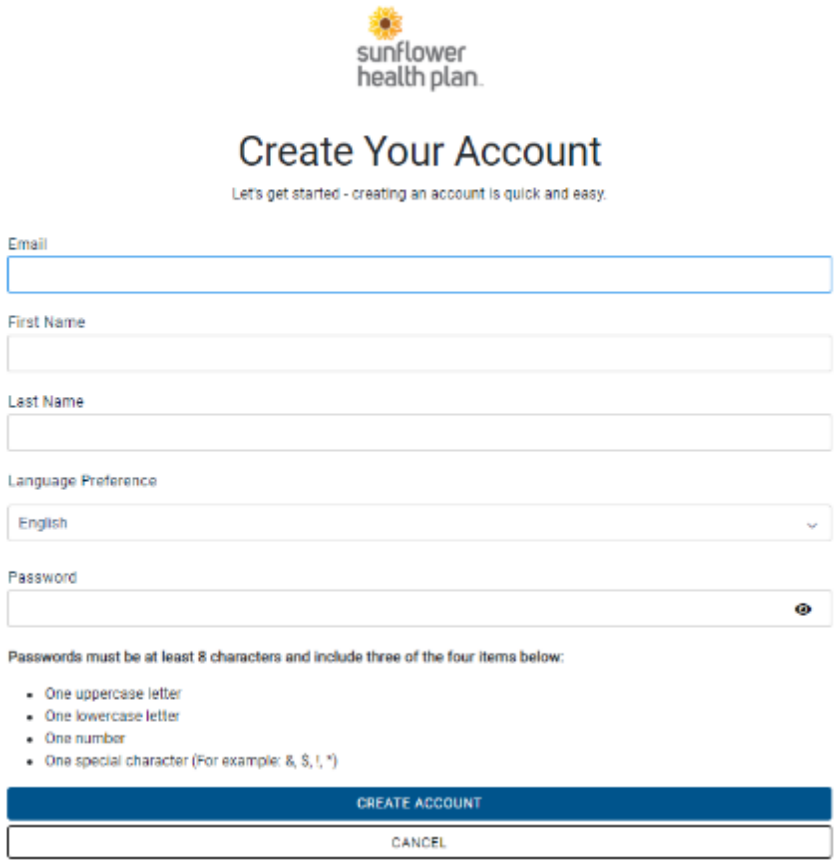
Secure Provider Portal

REGISTRATION IS FREE AND EASY!

Contact your Practice Account Manager or Provider Relations to get started!

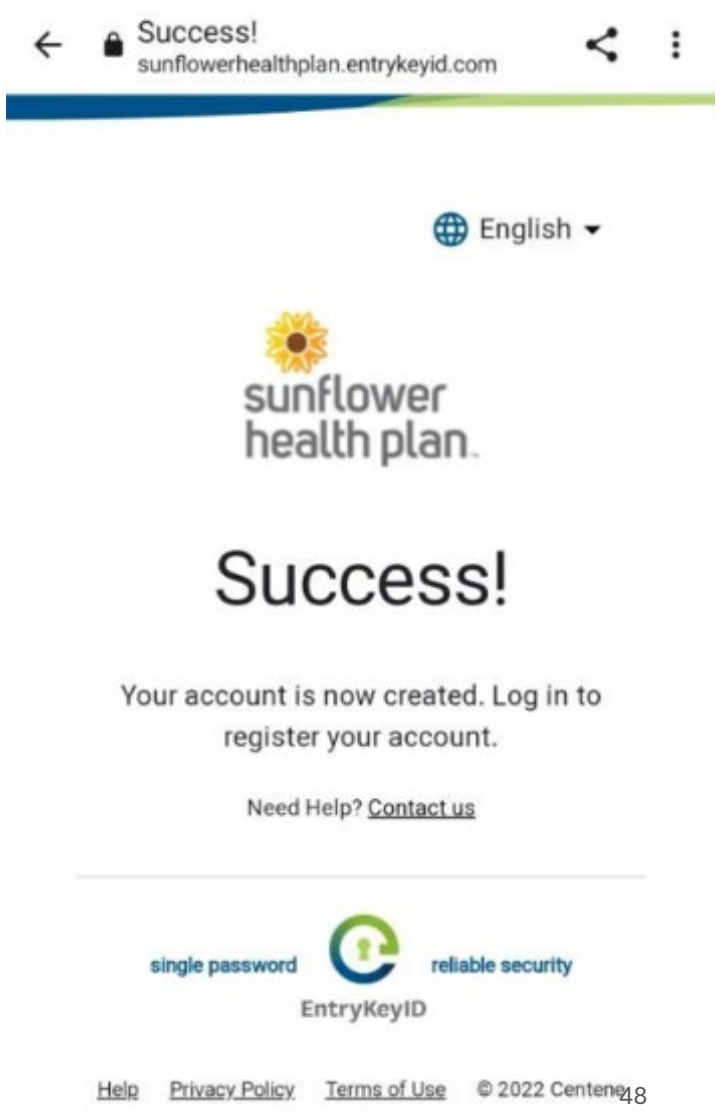


New Portal Users – Create Your Account



Once you have clicked the Create Account button, you should receive this **Success!** response.

Before you can access the portal, your account will then need to be verified by the Account Manager at your practice or by the health plan. Contact your Provider Relations rep to verify your account.

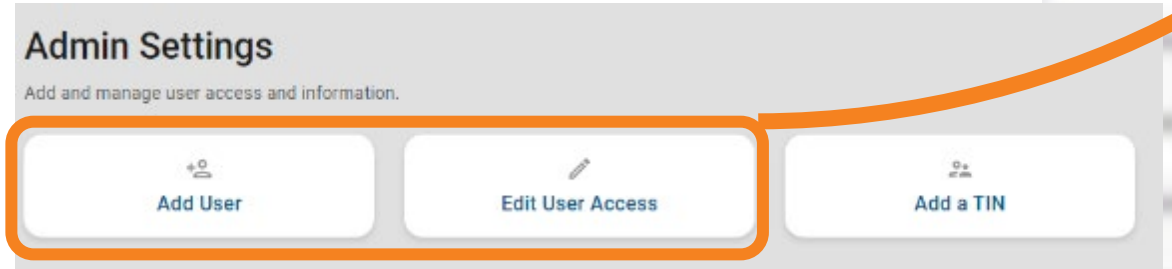


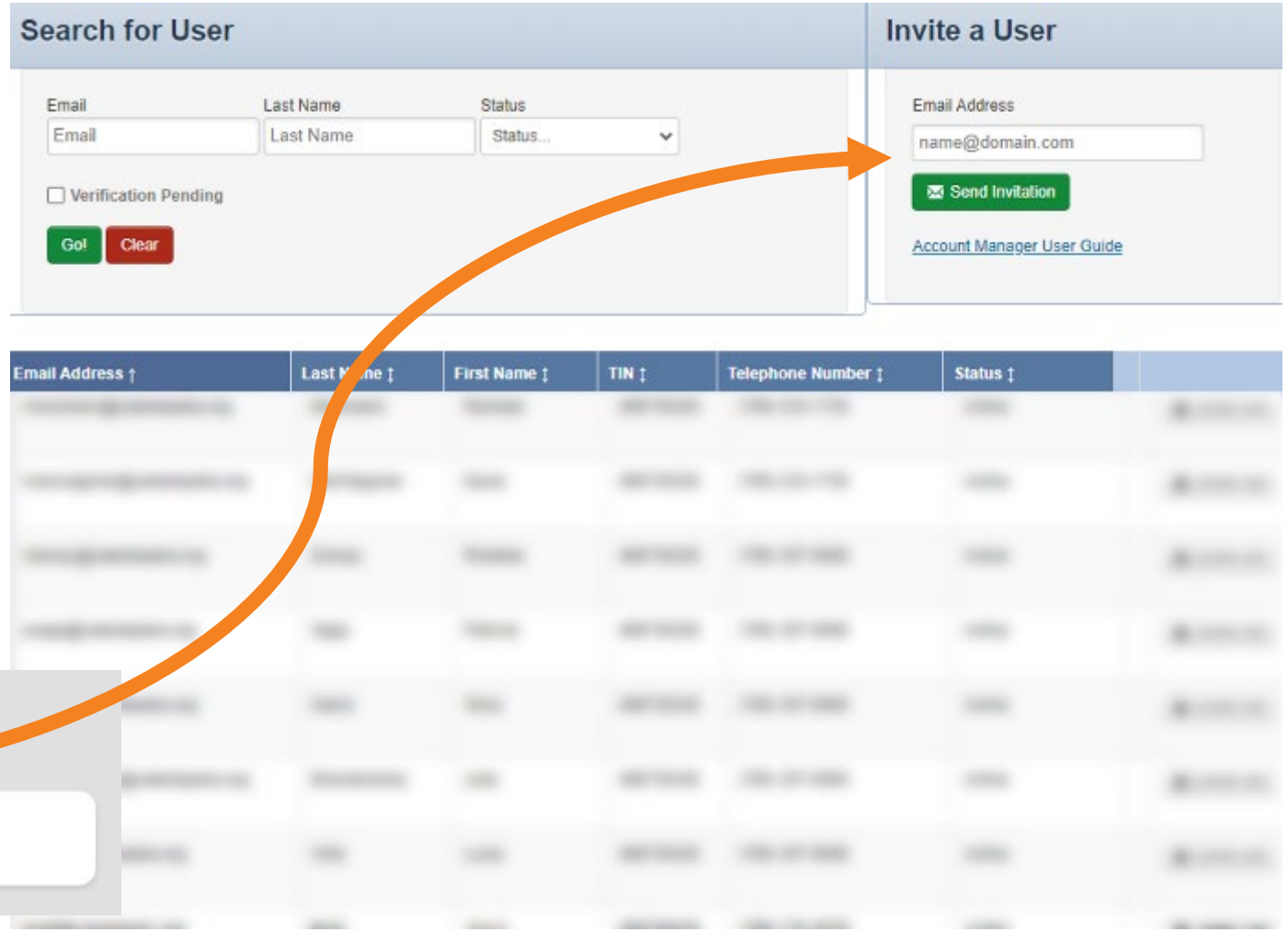
Secure Provider Portal – Account Manager

Role: The primary point of contact between the provider's office and the health plan.

Responsibility: At a practice is responsible for the day-to-day support of all the other user accounts registered for the same Tax Identification Number (TIN).

- Verify new users for their TIN
- Enable or disable access to the portal for existing users
- Change the permissions of all users under their TIN



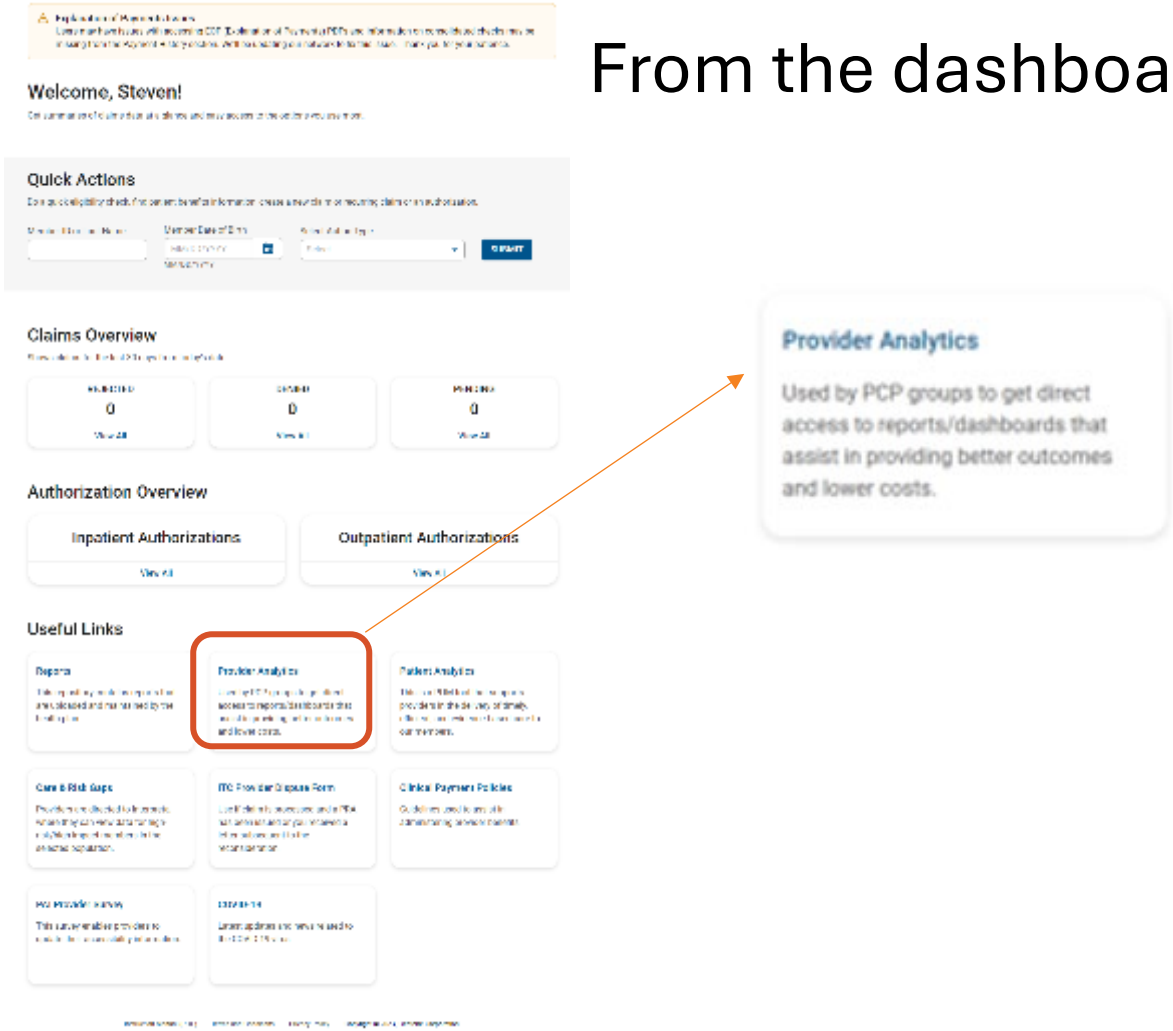


Secure Provider Portal

What's On The Secure Provider Portal?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals

Secure Provider Portal – Reporting Access



From the dashboard select Provider Analytics.

Provider Analytics

- Supplemental Reports – COVID-19 Detail, Daily IP & Discharge, Weekly Medical and Rx Claims
- P4Q and Quality Reporting – Quality and P4Q Appointment Agenda
- Dashboard Reports – Summary and Cost Utilization/Services

Questions about reporting please send an email to providerengagement@sunflowerhealthplan.com

Secure Provider Portal

INSIGHTFUL REPORTS

PCP reports available on the provider.sunflowerhealthplan.com are generated monthly and can be exported into a PDF or Excel format.

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

For additional support with these reports, contact providerengagement@sunflowerhealthplan.com

Availity Essentials

Sunflower has chosen Availity Essentials as its new, secure provider portal.

- Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials.
- Our current secure portal is still available for other functions that providers use today.
- An Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - www.Availity.com/documents/learning/LP_AP_GetStarted
  - Providers needing additional assistance with registration can call Availity Client Services at 1-800-AVAILITY (282-4548), Monday through Friday, 7 a.m. – 7 p.m. CT.
- For general questions, providers can reach out to their health plan Provider Engagement representative.

Claims 101

Who can file a claim?

- All providers – whether in-network or out-of-network – who have rendered services to Sunflower members can file claims.

How can claims be filed?

- Electronic
  - EDI direct submission completed via Provider Portal
  - EDI submission completed via a clearinghouse
- Provider Portal
- Paper claims can be mailed

Coordination of Benefits (COB) & Third-Party Liability (TPL)

- Sunflower is always the payer of last resort.
- Bill the primary coverage first, unless the services are on the KMAP TPL Noncovered Procedure Code List.
- Tertiary medical claims must be billed on paper claim forms and mailed.

Go to www.sunflowerhealthplan.com for additional details.

Billing Definitions

Billing the Member

- Providers may not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against members for covered services in the event, including but not limited to, non-payment by Sunflower, health plan insolvency, or breach of the agreement between Sunflower and the provider.

Clean Claim

- A claim that can be processed without obtaining additional information from the provider of services or from a third party.

Non-Clean Claim

- Defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in:
  - A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim;
  - A need for review of additional medical records; or
  - A need for other information necessary to resolve discrepancies.
  - May involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Advance Beneficiary Notice for Fee-for-Service Medicaid Program

- The KMAP beneficiary can be held responsible for payment of common services and situations. Beneficiaries can be billed only when program requirements have been met, and the provider has informed the beneficiary in advance and in writing. The provider must notify the beneficiaries in advance if a service will not be covered. To ensure the beneficiary is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the beneficiary prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.
- For services where there is normally no face-to-face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed annually by the beneficiaries with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.
- Providers are not to charge a KMAP beneficiary for services denied for payment by KMAP because the provider has failed to meet a program requirement including PA.
- Providers shall not bill beneficiaries for missed appointments. Missed appointments are not a distinct reimbursable service but a part of the providers' overall cost of doing business.
- For additional details, please refer to the KMAP General Benefits Provider Manual

Claims Payments: Electronic Funds Transfer

Payspan: A Faster, Easier Way to Get Paid

- Sunflower offers Payspan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently use Payspan, you will need to register specifically for Sunflower

Set up your Payspan account:

- Visit www.payspanhealth.com and click Register
- You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

See the Guide for How to Register for Payspan Health on our website.

Claim Timely Filing and Processing

Claim Submission Timely Filing	
180 Days	From the date of service (DOS)
	From the date of eligibility determination
	When the member has other insurance, from the date on the primary payer's EOP
60 Days	To refund overpayments or establish a payment plan
365 Days	To submit corrected claims

Sunflower Claim Turn Around Timeframe	
30 Days	To pay or deny clean claims
	To pay claims before interest begins to apply
	To pay or deny corrected claims
90 Days	To pay or deny non-clean claims

Claim Resolution Process

	Reconsideration (This step is optional)	Appeal	External Independent Third-Party Review (EITPR)	State Fair Hearing
Deadline to Submit	Within **120*** calendar days from the date of the EOP.	Within **60*** calendar days from date of the EOP.	Within **60*** calendar days from the date of the notice of appeal resolution.	Within **120*** calendar days from the date of the notice of appeal resolution.
How to submit	Call Customer Service: 1-877-644-4623 Mail: Address listed in EOP Provider Portal: Claim detail submit Claim Reconsideration	Completed Claim Appeal form Mail: Address listed in EOP Provider Portal: Claim detail submit Claim Appeal	Completed EITPR Request Form Mail: Sunflower Health Plan Appeals Dept., 8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214 Fax: 1-888-453-4755	Phone: 1-785-296-2433 Mail: Office of Administrative Hearings (OAH) 1020 Kansas Ave., Topeka, KS 66612
Resolution Details	Notification Type: Revised or unrevised EOP (for same claim number). Timeline: Will be resolved within 30 calendar days of receipt.	Notification Type: Written Provider Appeal Resolution Notice Within 10 calendar days, provider will receive a written acknowledgment of their appeal request. Within 30 calendar days from date of receipt, a resolution decision	Notification Type: Written resolution notice from Sunflower Health Plan.	Notification Type: Written communication from OAH Timeline: Varies at discretion of OAH

*Three additional calendar days will be allowed for mailing time. For additional information please see Provider Manual, EOP or resolution decision letter.

Quality Improvement Program

Goal of Quality Program

- Is to improve members' health status through a variety of meaningful, quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.
- Patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events.

Quality of Care Review Process – Overview for Providers

Our Quality of Care process ensures that patient safety and care standards are consistently met. When concerns are identified, they are assessed and categorized based on their impact on patient outcomes. The categorizations helps us determine the appropriate level of collaboration.

Purpose

The process is designed to identify opportunities for improvement and initiate quality improvement activities that lead to improved systems and patient safety.

Review of Concerns

Utilizing provider outreach for collaboration, each concern is reviewed using a structured framework that considers factors such as patient harm, risk and system gaps.

Action Steps

Education & Feedback – Providers receive feedback and resources to reinforce best practices.
Process Improvement – System wide change(s) are implemented when patterns or risks are identified.
Escalations – More significant concerns may involve formal reviews, additional training, or collaboration with leadership to address root causes.
Monitoring – All Quality of Care concerns and outcomes are tracked and analyzed.

Key Takeaways

The goal is not punitive – it's about continuous quality improvement and shared accountability for safe, high-quality care.

Quality of Care Review - How It Works

Every reported concern is assessed to determine if a quality of care concern is present and if the appropriate response was rendered. Actions vary depending on the potential impact on patient safety and care quality

No concern identified	Case is closed.
Minor Issues or Trends	Case is closed but monitored for patterns over time.
Moderate Concerns	Reviewed by clinical leadership: Actions may include education, process improvement and/or quality improvement activities.
Significant Concerns	Required detailed review and may involve credentialing, quality improvement plan(s) and/or peer review.
Critical Outcomes	Escalated for comprehensive review by leadership and committees, quality improvement plan(s) and monitoring.

Performance Improvement Plan

- Adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities.
- Initiatives are selected based on data that indicates the need for improvement in a particular clinical or nonclinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

HEDIS

HEDIS stands for:

Healthcare **E**ffectiveness **D**ata and **I**nformation **S**et

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) used to measure the quality of healthcare that patients receive from their provider groups/clinics. If gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simple cost differences.

The purpose is to:

1. Measure the Quality of Healthcare
2. Create Standards for Comparison
3. Help Improve Patient Outcomes

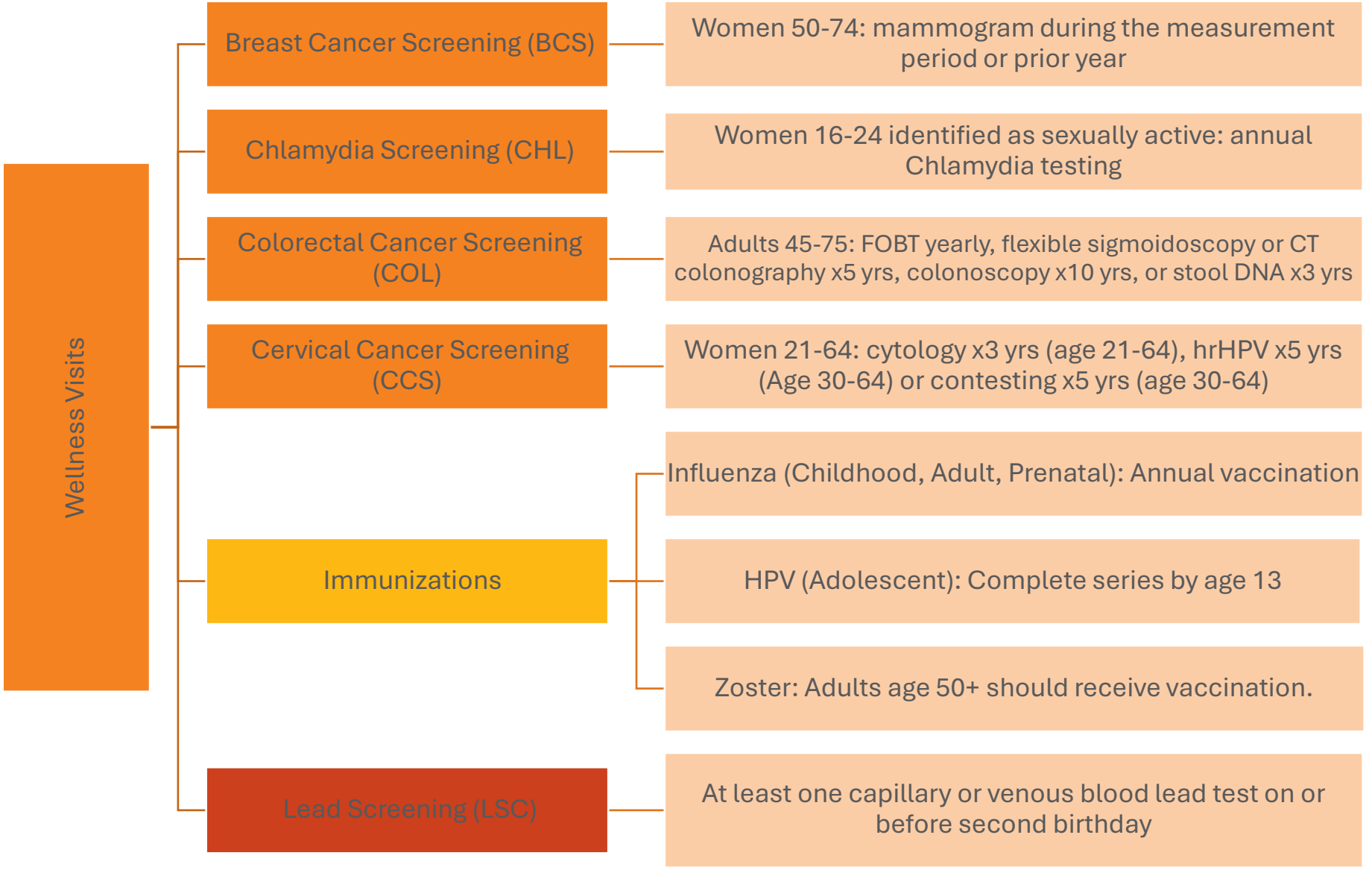
HEDIS Scores – Physician-specific scores are used to measure PCP practice's preventive care efforts.

Healthcare Effectiveness Data and Information Set (HEDIS)

How can providers improve their HEDIS Scores?

- **Knowledge & Understanding of HEDIS Measures**
- **Submit Claims Including CPT II & Encounter Claims**
- **Chart Documentation Reflects Services Provided**
- **Data Sharing via Supplemental Data or EMR Connectivity**
- **Provide Medical Records When Requested**

Making an Impact: *Annual Preventative Wellness & Screenings*



The guidelines listed are based on NCQA HEDIS® 2026 technical specifications for quality measurement and reporting purposes. They are not intended to replace clinical judgment or individualized patient care.

2026 Medicaid HEDIS Measures

AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	DBM-E - Documented Assessment After Mammogram	PBH - Persistence of Beta-Blocker Treatment After a Heart Attack
AAF-E - Follow-Up After Acute and Urgent Care Visits for Asthma	DBO - Deprescribing of Benzodiazepines in Older Adults	PCE - Pharmacotherapy Management of COPD Exacerbation
AAP - Adults' Access to Preventive/Ambulatory Health Services	DMH - Diagnosed Mental Health Disorders	PCR - Plan All-Cause Readmissions
ADD-E - Follow-Up Care for Children Prescribed ADHD Medication	DMS-E - Utilization of the PHQ-9 to Monitor Depression Symptoms	PND-E - Prenatal Depression Screening and Follow-Up
AHU - Acute Hospital Utilization	DRR-E - Depression Remission or Response for Adolescents and Adults	PNS-E - Postpartum Depression Screening and Follow-Up
AIS-E - Adult Immunization Status	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults	POD - Pharmacotherapy for Opioid Use Disorder
APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics	DSU - Diagnosed Substance Use Disorders	PPC - Prenatal and Postpartum Care
APP - Use of First-Line Psychosocial Care for Children on Antipsychotics	EED - Eye Exam for Patients With Diabetes	PRS-E - Prenatal Immunization Status
ASF-E - Unhealthy Alcohol Use Screening and Follow-Up	FMA-E - Follow-Up After Abnormal Mammogram Assessment	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia
AXR - Antibiotic Utilization for Respiratory Conditions	FUA - Follow-Up After Emergency Department Visit for Substance Use	SMC - Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
BCS-E - Breast Cancer Screening	FUH - Follow-Up After Hospitalization for Mental Illness	SMD - Diabetes Monitoring for People With Diabetes and Schizophrenia
BPC-E - Blood Pressure Control for Patients With Hypertension	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder	SNS-E - Social Need Screening and Intervention
BPD - Blood Pressure Control for Patients With Diabetes	FUM - Follow-Up After Emergency Department Visit for Mental Illness	SPC-E - Statin Therapy for Patients With Cardiovascular Disease
CBP - Controlling High Blood Pressure	GSD - Glycemic Status Assessment for Patients With Diabetes	SPD-E - Statin Therapy for Patients With Diabetes
CCS-E - Cervical Cancer Screening	HDO - Use of Opioids at High Dosage	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
CHL - Chlamydia Screening	IET - Initiation and Engagement of Substance Use Disorder Treatment	TFC - Topical Fluoride for Children
CIS-E - Childhood Immunization Status	IMA-E - Immunizations for Adolescents	TSC-E - Tobacco Use Screening and Cessation Intervention
COL-E - Colorectal Cancer Screening	KED - Kidney Health Evaluation for Patients With Diabetes	UOP - Use of Opioids From Multiple Providers
COU - Risk of Continued Opioid Use	LBP - Use of Imaging Studies for Low Back Pain	W30 - Well-Child Visits in the First 30 Months of Life
CRE - Cardiac Rehabilitation	LSC-E - Lead Screening in Children	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity
CWP - Appropriate Testing for Pharyngitis	OED - Oral Evaluation, Dental Services	WCV - Child and Adolescent Well-Care Visits

For additional HEDIS information www.sunflowerhealthplan.com/providers/quality-improvement/hedis.html

Why Did We Receive a Request for Medical Records?

You may receive a request from Sunflower's Medical Management, Quality, Auditing department, etc. We would like to remind you that Medical Records are required by contract for:

- All covered members (including those dual eligible where Sunflower was not payer of service provided)
- Contractual reasons for record requests
- To conduct utilization or quality review of member care
- Regulatory audits, monitoring, or reviews by the state, federal government or MCO
- To meet document requests required by accrediting organizations
- Public official requests

www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Sunflower-Chasing-the-Chart-Provider-Info.pdf

Medical Record Requests & Review for Quality

Provider Responsibilities:

- Documentation needs to fully meet request (read request document carefully and include all items in request)
- Timely submission (all requests will include a deadline and a contact number for questions, to discuss delivery, or if an extension is available)
- Submit documents in a secure, useable format (email, fax, upload to portal or mail)
- Specialists are to provide reports back to the member's PCP on a regular basis for coordination of care
    - Always submit medical records in PDF format

Medical Record Documentation

Provider Responsibilities:

- To maintain clinical and medical records in a manner that is current, detailed and organized.
- Retain medical records for 10 years with additional details explained for extending the record retention timeframe noted in the provider manual.
- Maintain the confidentiality of clinical and medical record information and release the information in the following manner:
- All clinical and medical records of members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.
- Written consent of the member is only required for the transmission of the clinical and medical record information of a former enrolled member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable protection laws.
- Authorization is not required when the provider is transitioning care to another KanCare provider.
- The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or a facility requesting the information.
- All releases of information for SUD specific clinical or medical records must meet federal guidelines at 42 CFR Part 2.

Quality Resources

Providers

- HEDIS Provider Resources
- EPSDT Provider Reference Kit
- Quality Care Pointers for Providers (PDF reference resource) - Helping your Sunflower patients achieve a Healthier Today, Better Tomorrow.
- State's Immunization Registry – Learn more about KANPHIX
- Reporting
  - Secure Provider Portal
  - www.availity.com

Members

Office Visit Checklist

- English
- Spanish

Changing assigned PCP - Member PCP Change Request

- English
- Spanish

Health and Wellness Tools

- Teladoc
- WebMD
- On.Target
- Health Books

Satisfaction Surveys –
We want you to be completely satisfied

- Provider Satisfaction Survey includes questions to evaluate provider satisfaction with our services such as:
  - Claims
  - Communications
  - Utilization Management
  - Customer Service
- Member Satisfaction Survey provides information on the experiences of members with:
  - Health plan
  - Access to Care
  - Care Coordination
  - Provider Communication and Services
  - Quality of Healthcare

Medicaid Key Contacts

- Member eligibility or liability concerns - call KanCare Clearinghouse 1-800-792-4884
- Issues with AuthentiCare - call 1-800-441-4667 or email authenticare.support@fiserv.com
- Kansas Dept of Aging & Disability Services – call 1-785-296-4986
- Kansas Dept of Health & Environment - call 1-785-296-1500
- HCBS Authorization concerns – email HCBSAuthorizations@sunflowerhealthplan.com
- Sunflower Provider Services – call 1-877-644-4623 (TTY 711)
- Contracting & credentialing questions – email sunflowerstatehealth@centene.com
- Sunflower Medicaid Physical Health Provider Relations Map
- Sunflower Medicaid HCBS/LTSS Provider Relations Map
- Sunflower Medicaid Behavioral Health Provider Relations Map
- Sunflower Medicaid Case Management Territory Map

How to Reach Us

Resource	Sunflower - Medicaid	Ambetter - Marketplace	Wellcare - Medicare Advantage
Website - Provider Resources	www.sunflowerhealthplan.com/providers/resources.html	ambetter.sunflowerhealthplan.com/provider-resources/manuals-and-forms.html	www.sunflowerhealthplan.com/providers/allwell-provider.html
Customer Service	1-877-644-4623 TTY: 711	1-844-518-9505 TTY: 844-546-9713	1-800-977-7522 DSNP 1-877-796-6811 TTY: 711
Secure Provider Portal	www.sunflowerhealthplan.com/login.html		
Contact Us Submission	www.sunflowerhealthplan.com/contact-us.html	ambetter.sunflowerhealthplan.com/contact-us.html	wellcare.sunflowerhealthplan.com/contact-us.html
Contracting & Credentialling Status Inquiries	sunflowerstatehealth@centene.com		

Questions?

Submit Training Feedback

Provider Training Questions
Provider_Training@sunflowerhealthplan.com

General Questions
providerrelations@sunflowerhealthplan.com

Thank You.

sunflower health plan