



Who Should I Call?--Provider

Question or Issue	Contact
To contract with an MCO	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
Check KanCare eligibility for a consumer	KMAP: Automated Voice Response System (AVRS) – 1-800-933-6593 or Web at https://www.kmap-state-ks.us/ Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
Check MCO assignment for a consumer	KMAP: Automated Voice Response System (AVRS) – 1-800-933-6593 or Web at https://www.kmap-state-ks.us/
If a patient has no ID card	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To talk with an MCO about a billing/claims issue	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
If you have a question or problem with the State's Front End Billing (FEB) solution	KMAP: 1-800-933-6593
To find my provider representative (advocate)	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235 or UHCcommunityplan.com
To look up what services need prior authorization	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To get authorization for a service	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-866-604-3267
Check if a provider is in an MCO's network	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To request materials or training	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235



Question or Issue	Contact
If you're a physician and want to see your panel size	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To determine which case manager is assigned to a particular consumer	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To ask questions regarding EVV (Authenticare)	First Data Help Desk 1-800-441-4667 option 6 clientsupport@firstdata.com
To ask questions regarding plans of care	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9235
To file a Grievance	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9238
To file an Appeal	Amerigroup: 1-800-454-3730 Sunflower: 1-877-644-4623 United: 1-877-542-9238

Beneficiaries Excluded from KanCare

The following table contains a current listing of the beneficiary eligibility categories excluded from the KanCare managed care program. All beneficiaries in one of the eligibility categories listed below will continue in the current Medicaid fee-for-service program after January 1, 2013.

Exclusions from KanCare	Description	FPL	Resource Standard
SOBRA 1903(v)(3)	This program is for non-citizens who are undocumented or who do not meet other non-citizen qualifying criteria and would otherwise qualify for Medicaid if not for their alien status. Eligible individuals may only receive coverage for approved emergency medical conditions.	Varies depending on the specific underlying medical program.	Varies depending on the specific underlying medical program.
QUALIFIED MEDICARE BENEFICIARY (QMB) 1902(a)(10)(E)(i) 1905(p)(1)	This program covers the Medicare out-of-pocket expenses of Medicare recipients, including premiums and co-payments. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.	100%	\$6940 (single) \$10,410 (couple)
LOW-INCOME MEDICARE BENEFICIARY (LMB) 1902(a)(10)(E)(iii)	This program only pays the Medicare Part B premium eligible Medicare recipients. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.	120%	\$6940 (single) \$10,410 (couple)
EXPANDED LOW-INCOME MEDICARE BENEFICIARY (E-LMB) 1902(a)(10)(E)(iv)(I)	This program also only pays the Medicare part B premium for eligible Medicare recipients. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.	135%	\$6940 (single) \$10,410 (couple)
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE) 1934	This program is for disabled individuals age 55 years or older residing in selected counties within the state. Eligible individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Individuals eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of care.	\$62/month (institution) \$727/month (HCBS)	\$2000
AIDS DRUG ASSISTANCE PROGRAM (ADAP)	This program is for individuals diagnosed with AIDS. Coverage for eligible individuals is limited to payment of prescription drugs related to treatment of AIDS.	\$2,793/month	There is no resource test.
TUBERCULOSIS	This program is for individuals diagnosed with tuberculosis and in need of care for this condition. Coverage for eligible individuals is limited to inpatient hospital care or alternative community based services related to the condition.	There is no income test.	There is no resource test.
MEDIKAN	This program is for individuals who qualify for a cash payment under the General Assistance (GA) program. Eligible individuals must meet	\$267/month (single) \$352/month	\$2,000 (single) \$2,000

Exclusions from KanCare	Description	FPL	Resource Standard
	program disability guidelines and must not be eligible for Medicaid.	(couple)	(couple)
RESIDENTS OF MENTAL HEALTH NURSING FACILITIES and STATE MENTAL HEALTH HOSPITALS (ages 22-64)	These programs is for individuals residing in a mental health nursing facility (NFMH) or state mental health hospital for a long term stay who are between the ages of 22 and 64 years old. Individuals eligible under these programs whose income exceeds the protected income level are responsible for a portion of the cost of their care in the facility. Individuals residing in an NFMH or state mental health hospital who are under the age of 22 or over the age of 64 are included in KanCare.	\$62/month	\$2,000
LONG TERM INSTITUTIONAL CARE 1902(a)(10)(A)(ii)(V)	Individuals residing in a public ICF/MR. Individuals residing in a private ICF/MR are not excluded from KanCare and will be enrolled in a KanCare health plan.	300% SSI \$62/month Personal Needs Allowance	\$2,000
I/DD LONG TERM SERVICES AND SUPPORTS (LTSS)	LTSS for individuals with intellectual or developmental disabilities (I/DD) are delayed entry into KanCare until January 1, 2014. I/DD waiver consumers will be enrolled in KanCare for all non-waiver services.		

Continuity of Care in KanCare January 2013

In KanCare, the State of Kansas wants to preserve continuity of care for members who have appointments and established relationships with providers prior to January 1, 2013. For all KanCare members, the three health plans (managed care organizations – MCOs) must honor all plans of care, prior authorizations, and established provider-member relationships during the transition to KanCare. This means that even if an established provider is not in an MCO's network, the provider will still be paid at 100% of the Medicaid fee-for-service (FFS) rate through the first 90 days.

For KanCare members currently living in a Medicaid-reimbursed residential setting, such as nursing facilities, the MCOs will pay those facilities for services at the Medicaid FFS rate for one year, whether or not the provider is in the MCO's network.

For people receiving home and community based services (HCBS) through one of the HCBS waivers, up to an additional 90 days will be available for existing plans of care and providers if a new plan of care is not in place within 90 days of Jan. 1, 2013. This means that HCBS members could have up to 180 days to continue with their existing services and providers, whether or not they are in the MCO's network.

Note: Providers who are not yet contracted or credentialed with one or more MCOs do not need to prior-authorize every service during the KanCare transition. During the first 90 days of KanCare, participating and non-participating providers alike should follow the plans' PA/notification policies for participating providers.

KanCare members were pre-assigned to one of the three MCOs in November 2012. However, they had the rest of 2012 and will have 90 days after January 1, 2013 (until April 4, 2013) to choose which plan they want to be in. Any choices made after January 1, 2013, will take effect the first day of the following month.

The three KanCare MCOs must make sure specialty care is available to all members. They are required to meet federal and state distance or travel time standards. If an MCO does not have a specialist available to members within those standards, it must allow members to see out-of-network providers. In KanCare, if an MCO is unable to provide medically necessary services in its network, it must cover those services out of network, and must have single-case arrangements or agreements with non-network providers to make sure members have access to covered services. The rate will be negotiated between the plan and the provider, and providers cannot bill members for any difference.

Emergency services are not limited to in-network hospitals. As required by federal law, the State's KanCare contract requires each MCO to cover and pay for emergency services, including services needed to evaluate or stabilize an emergency medical condition, regardless of whether the provider that furnishes the service has a contract with the MCO.

For other out-of-network services, after the transition, the State contract says MCOs will pay out-of-network providers that choose to serve KanCare members 90% of the Medicaid rate. Under federal law, the member cannot be made to pay the difference in standard rates and those paid by the MCO.