Continuity of Care in KanCare

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.

KanCare members were pre-assigned to one of the three MCOs in November 2012. However, they will have the rest of 2012 and 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 Medicaid members 90% of the Medicaid rate. Under federal law, the Medicaid member cannot be made to pay the difference in standard rates and those paid by the MCO.