KanCare questions & answers

KMS asked the State to provide responses to the following questions related to the implementation and management of the new KanCare program. If you would like more information, please contact Ruth Cornwall at rcornwall@kmsonline.org or 800.332.0156.

Q: When will the state have all the MCO provider contracts approved?
A: Most of the contracts for physical health care have been approved by the State.

Q: If a provider is not contracted with a certain plan but sees a pt assigned to that plan will he be paid? If at a lower rate, where is that stated?
A: Yes, out-of-network providers will be paid, but at 90 percent of FFS. This is stipulated in the RFP Section 2.3.6.8 and in Question and Answer #289, Amendment 8, both of which are incorporated by reference in the MCOs' contracts with the State.

Q: If a provider is not contracted with a plan/no contract in place, can he balance bill? If not, please provide a reference that we can share with providers.
A: We're still researching this.

Q: What if there is an area in the state where a plan has little/no contracted providers? What happens to the patient? Is the plan penalized for that?
KanCare includes geographic network adequacy requirements to ensure that each plan provides a full range of services statewide.

Q: What will happen to the medical necessity policies and manuals on the KMAP website?
A: They will continue to reside where they are. The medical necessity requirements apply to KanCare and the State will still administer a very small FFS Medicaid program for those populations not included in KanCare.

Q: Will there be a grace period for the first few months in the event a long standing pt sees their doc who is not contracted with the assigned plan, but will be paid?
A: Yes. The MCOs will work to enroll the provider in their network and if they are unable to, they'll use a single case contract and work to try to find an in-network provider.

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Q: How will the WRAP payments, for RHCs, be handled?
A: MCOs are required to reimburse rural health clinics at the PPS rate. The State is considering updating/rebasing the data used to establish the PPS rate for RHCs.

Q: Has the state set timeframes for the plans by which they must respond to providers regarding prior authorizations?
A: We have not, but we have required the plans to be transparent in these requirements and encouraged them to automate as much of it as possible.

Q: What are the terms of the contract?
A: If you're referring to the contract with the MCOs, it is a three-year contract with two one-year renewal options.

Q: Has the state set a timely filing requirement for the plans?
A: The plans have agreed to the same requirement of 90 days, but plans and providers can negotiate longer timeframes up to 12 months. There will be exceptions for retroactive eligibility issues and cases where Medicaid is the secondary payer.

Q: Can a physician limit his/her panel?
A: Yes.

Q: How will patients be assigned to a plan if a physician doesn't sign a contract until the end of December?
A: The assignment algorithm looks at a variety of providers, so the person would be assigned by the next most frequently used provider. Remember the person has 45 days to switch plans beginning January 1, 2013.

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