KMAP GENERAL BULLETIN 24273

Continuity of Care and Authorizations for January 1, 2025

The KanCare 3.0 contract will begin January 1, 2025, with Healthy Blue, Sunflower Health Plan and United Healthcare Community Plan. The purpose of this bulletin is to inform providers of the Continuity of Care period and to provide instructions regarding prior authorization, including use of Electronic Visit Verification (EVV).

Continuity of Care:

Each Managed Care Organization (MCO) is required to provide Continuity of Care for members who come from another MCO. This includes honoring existing services that were authorized by the previous MCO and paying authorized providers at least 100% of the Medicaid fee schedule. Continuity of Care begins on the date the member is eligible with the new MCO.

- **Home and Community Based Services (HCBS):** HCBS service authorizations provided by the previous MCO will be utilized by the new MCO for up to 90 days, or until a new comprehensive assessment is completed and a Person-Centered Service Plan is developed. A member's existing HCBS service provider will be paid at 100% of the Medicaid fee schedule unless a different contract rate or Single Case Agreement is agreed upon by the new MCO and the provider.
- **Hospitalizations:** Aetna members that are hospitalized on or before December 31, 2024, we will be covered by Aetna for the first 15 days of January 2025 or upon discharge if discharged before January 15, 2025.
- **Other Services Requiring Prior Authorization:** The new MCO will honor the authorization provided by the previous MCO through the end date of the authorization, up to 90 days, and will pay the authorized provider at a minimum of 100% of the Medicaid fee schedule. For services to continue past the authorization end date, or the maximum of 90 days, the provider will need to submit a prior authorization request to the new MCO.

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  Monday - Friday

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Continuity of Care and Authorizations for January 1, 2025, continued

- **Single Case Agreements:** Continuity of Care does not apply to contract rates held by the previous MCO including Single Case Agreements for rates negotiated above the Medicaid Fee Schedule. Providers will need to make any requests to the new MCO. Single Case Agreements for out of network providers will be paid by the new MCO at the Medicaid Fee Schedule rate unless otherwise requested by the provider and agreed upon by the new MCO.

Transfer of Authorizations:

The State and MCOs have an established process for securely transferring prior authorization information for members moving from one MCO to another. This includes members moving from Aetna to Healthy Blue, Sunflower Health Plan and United Healthcare Community Plan.

If providers do not see a needed authorization on January 1, 2025, they may refer to the Continuity of Care information provided above for what will be paid. Providers may also reach the MCOs using the following contact information:

Healthy Blue:

- Long-Term Services and Supports (LTSS) Providers: ltssproviderrelations@healthybluekansas.com
- Physical Health Providers: ksproviderinquiry@healthybluekansas.com
- Behavioral Health Providers: provider.inquiry.ks@carelon.com

United Healthcare Community Plan:

- Physical/Behavioral Health: uhckancare_providerrelations@uhc.com
- LTSS:
- ksunited_longtermcare@uhc.com

Sunflower Health Plan:

- Provider Relations Representative: 1-877-644-4623.

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Electronic Visit Verification:

For the services for which use of EVV is required, EVV will continue to be required. Authorizations are either sent to or created in AuthentiCare. Providers and MCOs will need to ensure the proper provider ID/location is used on the authorization. Once correct, the Provider can accept the Authorization and schedule against it.

If an authorization from the new MCO is not present, the worker can continue to clock in and out using EVV following the AuthentiCare guidelines provided below. The provider may refer to the Continuity of Care information provided above to understand what will be authorized and paid. Providers may also contact each MCO using the contact list provided above.

AuthentiCare Instructions:

When a worker is ready to deliver services, they must either check in to AuthentiCare through the 1) the AuthentiCare Smartphone application; 2) the AuthentiCare Interactive Voice Response (IVR), or 3) an approved third-party vendor. If a worker is unable to use one of the three methods, then an approved administrator of the provider can manually enter visit information. If smart device and/or Wi-Fi connectivity is not available, AuthentiCare's mobile application allows for "store and forward" capabilities. In this case, the EVV information is stored at the time of service and uploaded to AuthentiCare when connectivity resumes.

When support is completed, the worker checks out of the visit by logging back in through one of the approved methods and completes the data entry to verify their visit and capture any observations. The information is then transmitted to the AuthentiCare application.
A worker can use the AuthentiCare Smartphone application or the IVR to record services, and the provider can create a web claim without an approved authorization in AuthentiCare as long as there is an established association between the member and the provider agency. When utilizing IVR for clock in, workers will be alerted that authorized units are not available and should follow the system prompts to acknowledge and provide unauthorized services. A claim will be created but will have a critical exception and will not be exported for payment until an authorization is in place with the status of *Approved.*

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