KanCare Billing and Payment

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) and Kansas Department for Aging and Disability Services (KDADS) have worked with the KanCare plans to document specific information for providers delivering nursing facility services and Home and Community Based Services (HCBS). Attached is detailed information from each KanCare plan regarding coordinating, billing, and payment for these services.

KMAP
Kansas Medical Assistance Program
- Bulletins
- Manuals
- Forms

Customer Service
- 1-800-933-6593 (in-state)
- 785-274-5990
  8:00 a.m. - 5:00 p.m.
  Monday - Friday

Amerigroup
Claims Processing Technical Document for Nursing Facilities/HCBS Providers

Amerigroup Provider Services/Provider Relations Contact Information and Resources

- Provider Services: 1-800-454-3730
- Provider Services: 1-800-454-3730

Amerigroup Kansas Provider Portal Address : Providers.amerigroup.com/KS

- Available to all providers regardless of participation status
- Key Transactions available on website
    - Claims submission
    - Claims verification
    - Precertification
    - Eligibility Reports

Verifying Member Eligibility

- Verifying member eligibility can be done through a couple of means:
    - **Visit the Kansas Medical Assistance Program (KMAP) website:** www.kmap-state-ks.us/
- **Call our Provider Services team:** 1-800-454-3730

Amerigroup Claims Submission Procedures

- **Claims Submission Clearinghouses:**
    - Emdeon (formerly WebMD): payer ID 27514
    - Capario (formerly MedAvant): payer ID 28804
    - Availity (formerly THIN): payer ID 26375
- Direct submission through Amerigroup website
- Continue submitting claims to the Kansas Department of Health and Environment (KDHE) via state MMIS
- Continued submission of paper claims to KMAP

  KMAP
  Office of the Fiscal Agent
  P.O. Box 3571 Topeka, KS 66601

- **Timeframes for accepting claims submissions**
    - AGP Web Portal accepts same day submission until 1p Central Time
    - KMAP Web Portal creates files every two hours | AGP retrieves between 8am – 12noon
    - Submitter receives reject notification from PMS or on 277CA for EDI submissions

Amerigroup Claims Payment Cycle

- Amerigroup pays claims on Tuesday, Wednesday, Thursday and Saturday

The following is a table of the claims payment cycle by submission source.

	Submission Source			
	FEB	**Clearinghouse**	**MCO Portal**	**Claim Status**
Claim Submission	Until 8a Daily	Cut-off May Vary	Until 1p Daily	Source Reject Report Only
o Deadline for claim entry will vary by vendor - submitters should confirm submission deadlines when using 3rd party sources o **Authenticare (EVV) submissions may experience up to 24 hours between authentication and claim file creation.**				
Claim Files Retrieval	8a - 12p Daily	8a - 12p Daily	2p Daily	File Reject Report - 277CA
o AGP retreives consolidated files from all sources once per day between 8am and 12 noon. o AGP creates a data reject report for any file that is not retrievable				
Claim Processing	12p - 6a Daily	12p-6a Daily	2p-6a Daily	Pending / Paid / Reject
o Consolidated claim files are processed once per day. Each claim successfully processed is assigned a status o AGP creates a written notice for any claim rejected which is mailed to the provider				
Claim Review	1-10 days	1-10 days	1-10 days	Pending / Paid by 6a on portal
o Currently AGP is manually reviewing every claim submitted to confirm the integrity of our adjudication process o After implementation clean claims will be assigned a paid status and process during the next cycle o Claims that require review may pend for an additional period | AGP will meet the state standard for TAT				
Pay/Deny Status (P/D-S)	1 day	1 day	1 day	Pending / Paid
o Claims placed in a paid/denied status will generate an EOP | EOPs process on Tues/Weds/Thurs/Sat				
EFT / Check Disbursement	1 day	1 day	1 day	Paid
o During the EOP process a EFT transaction file is created and sent through our vendor to banking institutions for disbursement of funds o Banking institutions vary on when funds become available in the customer's account				
Check Delivered	1-5 days	1-5 days	1-5 days	Paid
o Checks are sent USPS 1st Class | 1st Class delivery guarantee by USPS is 1-5 days				
Total Processing Time	4-17 days	4-17 days	3-16 days	Paid

Additional Notes on Nursing Facility Claims

- Bill UB-04 form
- Nursing facility bill type requirements: Nursing/Intermediate Care Facility Provider Manual. Billing Section, Paragraph 7020 pg. 7-3 specifies that Skilled Nursing Facilities should use Bill Type 21X; Intermediate Care Facilities should use 65X or 66X.
- Third party liability amount goes in box 39 with value code 23
- Submit the appropriate Revenue (REV) code for the services rendered
- Reimbursement to nursing facility is based on a per diem methodology according to the applicable KanCare nursing facility rates.

Amerigroup Nursing Facility Prior Authorization Requirements

- Prior authorization for a nursing facility stay is not required at any time if the member has Medicare as the primary payer.
- If a member enters the nursing facility through the Medicare skilled nursing benefit and the member exhausts their Medicare benefit and Medicaid becomes the primary payer for the stay, an authorization is needed for dates of service after Medicare criteria is no longer satisfied for a continued stay or the benefit is exhausted. ,
- If a member is admitted and Medicaid is the primary payer Amerigroup requires that an authorization be obtained.
- To obtain an authorization, the nursing facility provider may contact the LTSS unit at **1-877-434-7579 ext. 50103** and a long term services case specialist will assist you in obtaining the authorization.
- Information may also be faxed to **1-855-225-9937** where a long term case specialist will process the authorization.
- If a member enters the facility from a hospital, it is the nursing facilities responsibility to obtain the authorization if the person is entering the facility as Medicaid primary.
- If the admission is a planned, admission the nursing facility should obtain authorization 72 hours before the admission.
- For unplanned admissions, an authorization should be obtained the next business day.
- An authorization is not necessary when a member re-enters the facility if it is within the 10 bed reserve days. If the member exhausts the 10 reserve days and is re-admitted to the facility an authorization is required.

Important Amerigroup LTSS Contact Informatiion:

1-877-434-7579 ext. 50103 – For authorization and nursing facility questions

1-855-255-9937 – Fax number for authorizations

Claims Submission Methods:	1. Sunflower State Secure Web Portal at www.SunflowerStateHealth.com a. To register for the Portal: b. Go to www.SunflowerStateHealth.com. c. Click on "Log In". d. Click on "Register" under the Provider Secure Log in area e. Supply the information requested. f. You will receive an e-mail with a link. Follow the link to complete the registration process. 2. Submit claims electronically through one of the preferred Sunflower State EDI Clearinghouses: Emdeon, SSI, Gateway, Availity, and Smart Data Solutions. Our electronic payer id is 68069. If you are having issues with electronic billing, please call our EDI department at 800-225-2573 extension 25525 or e-mail at EDIBA@centene.com. 3. Submit claims through KMAP. Please see KMAP General Bulletin 12115 issued November, 2012. This bulletin is posted on the Sunflower State website. Click on For Providers, Provider Resources, Manuals and Guides, Guides – KanCare Bulletin-KMAP Billing. 4. For HCBS Providers, claims may be submitted through AuthentiCare. Claims will then be transferred to Sunflower State for final adjudication. 5. Submit paper claims to KanCare, PO Box 3571, Topeka, KS 66601-3571. <u>Long Term Care Wizard</u> The Web Portal offers a function called the Long Term Care Wizard. This function allows Nursing Home Facilities to build a patient list. Then, each month as claims are submitted, the admit date/service date can be updated and submitted rather than create a new claim each time. You must be a Registered User on the Secure Portal. To access the Long Term Care Wizard: 1. Click on Claims 2. Click on Multiple 3. Select either the CMS 1500 or CMS UB04 Claim Type 4. Select the Service Location for the claim. Click on the Name 5. When creating a claim for the first time, enter the Member ID, Birthdate and click Add Member 6. After adding the new member to the Member list, click the box on the left of Member Name 7. Complete all information as requested on the screen 8. To submit subsequent claims requires much less coding. Follow the above steps. From the Member List check members with subsequent claims and enter the new information to update the claim for the next billing cycle. Click on Update Dates to apply new dates to all checked members. This will put the claims under the Claims Ready to be Submitted section. Click on Submit Claims. <u>Home and Community Based Service Provider Submission of Electronic Visit Verification Claims with Third Party Liability</u> 1. Blanket Denials a. The State of Kansas will continue to maintain a standard blanket denial list that will be updated and distributed to all MCOs for application in our systems. If a blanket denial is available, the provider's claim will be received and processed without

Claims Submission Methods (con't)	coordination of benefits (COB) information being required. 2. Services without a Blanket Denial a. If a claim for services for a member with other insurance is submitted via AuthentiCare and no blanket denial is available, the initial claim will be received and denied back to the Provider with an explanation code (EX code) of L6 "Deny: Bill Primary Insurance First, Resubmit with EOB". 3. How to Provider COB Information After Denial a. Preferred method: A provider can access the initial claim submitted via the Sunflower State Provider Secure Portal. That initial claim can be corrected via the portal by providing the other insurance information and resubmitting the corrected claim. b. A provider can also submit a corrected claim electronically via a clearinghouse by following the appropriate corrected claim processing instructions located in the Sunflower State Billing Manual which is posted on the Sunflower State website. c. If an electronic option is not available to the provider, the provider can submit a paper corrected claim (following the corrected claim instructions in the Billing Manual) with a copy of the primary payer's Explanation of Payment to: KMAP, PO Box 3571, Topeka KS 66601-3571.
Provider Numbers	The Provider Number for Sunflower State is the Rendering Provider NPI number. If you submit claims through AuthentiCare, you utilize your State issued Medicaid ID Number. The AuthentiCare claim will be transmitted to Sunflower State who will match up the Medicaid ID Number with the NPI number in order to process the claim. If you are an HCBS provider, you are required to bill through AuthentiCare and must use your State-issued Medicaid ID Number.
Claims Status Methods:	1. Sunflower State Secure Web Portal a. Follow the instructions above to register for the Portal. b. All claims submitted to Sunflower State will be reflected in the Portal within 48 hours. If the claim is submitted via the secure portal, the claim should appear within 2 hours. As an example, if the claim is submitted via the KMAP site, once received by Sunflower State, the claim will be viewable in the Sunflower State Secure Web Portal. 2. Utilize the Sunflower State Interactive Voice Response (IVR) Line at 877-644-4623 and follow the prompts to check claims status. You will be required to utilize the NPI number, tax id, member ID and date of birth so have these items available in preparation for the call. 3. Call Sunflower State Provider Services at 877-644-4623 and follow the prompts to Provider Services.
Claims Remittance Methods:	1. Sunflower State utilizes PaySpan Health to administer Electronic Funds Transfer and Electronic Remittance Advice. a. To register for PaySpan call 877-331-7154 to receive the registration code. Go to www.payspanhealth.com and click the Register Now button. Enter the registration code, Provider ID Number (PIN) and Tax ID Number. b. A guide to PaySpan registration can be found on our website at http://www.sunflowerstatehealth.com/files/2012/12/How-to-Register-for-PaySpan-Health.pdf. 2. Paper Checks and Paper Remittance Advices

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<tr><td></td><td></td></tr>
<tr><td>Payment Frequency</td><td>
<table>
<tr><td></td><td>FEB</td><td>Clearinghouse</td><td>MCO Portal</td></tr>
<tr><td>From Claim Submission to Claim Received by MCO Claim's System</td><td><3 Business Days</td><td>1 Business Day or Same Day</td><td>1 Business Day or Same Day</td></tr>
<tr><td>From Claim Submission to Claim Appears on MCO Secure Portal with Current Adjudication Status*</td><td><4 Business Days</td><td>1 Business Day or Same Day</td><td>1 Business Day or Same Day</td></tr>
<tr><td>Number of Days for Pends and Other Claims Review From Date Claims Received by MCO</td><td>< 7 Business Days on Average</td><td>< 7 Business Days on Average</td><td>< 7 Business Days on Average</td></tr>
<tr><td>From Claim Received by MCO to Final Payable (Paid/Denied)</td><td>< 7 Business Days on Average

State Requirement = <20 Days for Clean Claims</td><td>< 7 Business Days on Average

State Requirement = <20 Days for Clean Claims</td><td>< 7 Business Days on Average

State Requirement = <20 Days for Clean Claims</td></tr>
<tr><td>From Claim Hitting Payable to EFT Received by Provider</td><td>1 Business Day or Same Day Depending on Bank</td><td>1 Business Day or Same Day Depending on Bank</td><td>1 Business Day or Same Day Depending on Bank</td></tr>
<tr><td>From Claim Hitting Payable to Provider Receiving Paper Check</td><td>2-4 Business Mail Days</td><td>2-4 Business Mail Days</td><td>2-4 Business Mail Days</td></tr>
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<tr><td></td><td></td></tr>
<tr><td>Specific-Identified Claims Issues as of January 17, 2013.</td><td><u>SNF Claims Incorrectly Routed to Cenpatico Behavioral Health</u>
SNF claims are incorrectly being routed to Cenpatico Behavioral Health (CBH) via the Front End Billing process through KMAP. CBH and the State continue to work to correct this programming. You may receive confirmation reports indicating the claims were re-routed to</td></tr>
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Please reference the Claims Issues Log posted on the Sunflower State web site for up-to-date information on verified claim payment issues.	CBH. Sunflower is manually voiding those claims and re-keying them into the medical account. There is nothing the SNF needs to do in this situation. Until the systemic issue is corrected, you may see a 2-4 day delay in your claims appearing on the Sunflower State Secure Provider Portal. If after 4 days, you claim doesn't appear, please contact Provider Services at 877-644-4623. The state has indicated the fix for this issue should be in production on Friday 1/18/2013. <u>SNF/LTC Claims with Admit Date Prior to 1/1/2013 – B2 Pends</u> • SNF and LTC providers may have experienced a delay in payment or may be seeing B2 pends when checking the claim status via the Secure Provider Portal. This is due to the fact that the admit date on the claim was prior to the Sunflower State effective date of January 1, 2013. • Any claims submitted with an admit date **on or after** January 1, 2013 will be adjudicated more quickly than claims submitted with an admit date **prior to** • January 1, 2013. Claims submitted with an admit date prior to January 1, 2013 require manual adjudication and this manual adjudication could potentially lead to a payment delay. • Sunflower did send a Fax Blast on January 22, 2013 confirming that claims can be submitted with an effective date prior to January 1, 2013. <u>HCBS Fee Schedule</u> With the assistance of HCBS providers, Sunflower State identified an issue within our fee schedules. The entire fee schedules have been re-worked to ensure that all issues are resolved. All affected claims should be reprocessed no later than February 8, 2013. <u>Intermediate Care Facility Type of Bill (TOB) 61X Invalid as of January 1, 2013</u> The State has issued a bulletin to providers indicating that claims should be rebilled using the Type of Bill of 65X or 66X. If the claim was submitted through KMAP, it should be corrected and resubmitted there. Please see the Sunflower State Provider Manual and Billing Manual posted on the website at www.SunflowerStateHealth.com for instructions on how to submit a corrected claim NOT initially submitted through KMAP.
General Claim Guidance	1. 21X is the correct bill type for Nursing Facilities. 2. Revenue Code 120 must be utilized to submit room and board charges 3. Revenue Codes 180, 181, 183, or 185 must be utilized for reserve days 4. Admitting diagnosis codes are required on all claims. 5. The admitting provider is required on all SNF claims. This is in accordance with HIPPA compliant billing rules. 6. Providers must code diagnoses to the highest level of specificity. That is, if the highest level of specificity is a diagnosis code with 4 digits, a diagnosis code containing 4 digits must be utilized when submitting the claim. This is also true for diagnosis codes where the highest level of specificity is 5 digits. 7. Sunflower State will follow the existing Kansas Medicaid Pricing Algorithm for processing professional and institutional Medicare-related claims. 8. Sunflower State will apply the Coordination of Benefits/Third Party Liability rules as stated in the State's TPL Manual that covers Long Term Care Insurance 9. Continue to complete the MS-2126 form and submit to the State. Sunflower does not need this form for claims processing. 10. Sunflower State accepts cross-over claims.

Provider Relations	Sunflower State has dedicated Provider Relations Specialists throughout the State. To determine who your dedicated Provider Relations Specialist is: 1. Visit our website at www.SunflowerStateHealth.com 2. Click on For Providers 3. Click on Provider Resources 4. Under Resources on the right hand side of the web page, click on Territories Map Providers may always call Provider Services at 877-644-4623 for information. Provider Relations Specialists are available to conduct Orientations and visits. If you have not already been contacted by your assigned Provider Relations Specialist, you may reach them by sending an e-mail to the e-mail address listed on the above Territories Map. Sunflower State sends Fax Blasts from time to time regarding important health plan information. These Fax Blasts are also posted on the website at www.SunflowerStateHealth.com.
Medical Management Scenarios	<u>Member is in a Nursing Facility as of January 1, 2013 – "Go-Live"</u> 1. The Sunflower Case Managers will be contacting each facility to identify themselves and to provide their contact information. If you have not heard from your Case Manager, call Sunflower at 877-644-4623 and follow the prompts to Waiver Case Management. 2. The Case Managers will be scheduling onsite reviews with these members and will advise the facilities of their schedule of when they expect to be at the Nursing Facility. 3. The Case Managers will always announce themselves when they arrive in the Nursing Facility. 4. The Case Managers may attend some Care Planning on occasion, especially when the Nursing Facility needs support with the member's family. 5. The Case Managers will work with the facilities when members choose to follow Money Follows the Person (MFP) programs and other discharge planning from the Nursing Facility. <u>Members being admitted to a Nursing Facility from an inpatient facility</u> 1. A Sunflower Concurrent Review Nurse will be involved in the case and as part of discharge planning will assist with transferring the member to the selected Nursing Facility. 2. The Concurrent Review Nurse will provide a listing of available Nursing Facilities 3. The Concurrent Review Nurse will work with the hospital discharge planner to ensure appropriate authorizations are in place to transfer the member 4. The Sunflower State Concurrent Review Nurse will also ensure authorizations for any services or equipment needed outside of the Nursing Facility Covered Services/Items are in place as indicated by the Sunflower Prior Authorization list. 5. The length of the authorization will depend on the member diagnosis, acuity and intended treatment plan. The length of the authorization will be shorter for skilled and rehabilitative admissions. 6. Authorizations for custodial care will be at six month intervals so that the Sunflower State case manager can reassess member status at least semi-annually and upon significant change.

Medical Management Scenarios (con't)	<u>Members being admitted directly from home or an assisted living facility</u> 1. The admitting physician and/or receiving Nursing Facility should contact Sunflower's Prior Authorization department 5-7 days in advance of the admission or as soon as the need for admission is identified 2. The member will be assigned a case manager who will work with the family and the Nursing Facility to ensure a smooth transfer 3. The Case Manager will ensure appropriate authorizations are in place as noted above and schedule transportation as indicated. 4. Sunflower will require information related to any medical conditions, physician admitting orders, and a level of care assessment (CARE assessment if available) and proposed treatment plan. 5. Sunflower will use InterQual criteria to review for medical necessity of the admission and the appropriate level of care. <u>Member discharge from a Nursing Facility to a lower level of care:</u> 1. The Sunflower State Case Manager should be engaged as early as possible in the discharge planning process. 2. The Sunflower State Case Manager will assist with identifying and obtaining authorizations for any home and community based services and/or medical equipment needed to maintain the member safely at home. 3. The Sunflower Case Manager will also assist with setting up transportation, follow-up physician appointments, and outpatient treatment as indicated by the member's treatment plan. **In all scenarios, the Sunflower State Case Manager is empowered to approve authorization at the time of receipt of all necessary clinical information. As such, Sunflower does not anticipate any lost days of reimbursement between the hospital, Nursing Facility or home and community based services.** **NurseWise is Sunflower State's 24 hour 365 service which is staffed by registered nurses. Should you have any questions regarding admissions after hours, on weekends, or on holidays, you may reach NurseWise at 877-644-4623.**

UnitedHealthcare Community Plan

Dear Providers:

As we move forward with the KanCare transition and providers begin to submit claims, many natural questions and concerns have been raised. We would like to assist with providing some additional information about the claim and authorization processes to help address provider questions and concerns and to make the transition process as smooth as possible.

Claim Submission and Timeline

We encourage all providers to submit claims for January dates of service as soon as possible rather than waiting for your regular billing cycle. The submission of at least a few claims will allow us to verify that your claims are flowing through the process correctly.

Providers may submit claims electronically through a claim clearinghouse. Our payer ID for KanCare is 96385. Providers (both contracted and non-contracted) who bill on a HCFA 1500 claim form may also submit directly through the UnitedHealthcare provider portal once the provider is loaded in the UnitedHealthcare claim system and has established a user name and password on the secure website. You may also submit paper claims to the following address:

KMAP
P.O. Box 3571
Topeka, KS 66601-3571

If you continue to submit claims through the state's Front End Billing (FEB) process, the claims follow this general claim timeline:

- The claims will be received and loaded into our system within 24 – 48 hours of your submission through the FEB
- You will be able to see your claims in our web portal approximately 3-4 days from your FEB submission.
    - You will not be able to check the paid status of your claims on the KMAP website for dates of service on or after 1/1/2013.
    - Participating and non-participating providers can check claim status on UHCOnline.com after you create a user name and password on the secure website.
    - Providers must be loaded in the claim system to create a user name and password.

	FEB	Clearinghouse	MCO Portal HCFA1500 only	Claim Status on MCO Web Portal Appears As
Claim Submission	-	-	-	-
Claim Transferred	1 day*****	1 day	Immediate	-
Claim Reviewed	1-10 days	1-10 days	1-10 days	Pending – viewable approx. 3 days after claim transferred
Payment/Denial Determination	1 day	1 day	1 day	Paid/Denied
EFT Transaction (If applicable)	1 day	1 day	1 day	Paid/Denied
Check Cut (If applicable)	1 day	1 day	1 day	Paid/Denied
Check Delivered	1-3 days	1-3 days	1-3 days	Paid/Denied
Total Processing Time	4-17 days	4 17 days	3-16 days	Paid/Denied

*****Claim Transferred referred to claims being transferred from EVV (where applicable) to HP and then from HP to UnitedHealthcare.

- Your Provider Advocate can assist you with setting up your user name and password on our website, and can provide training on how to check member eligibility and claim status.

You may also contact our Provider Call Center at 877-542-9235 for assistance with claim status.

During the transition period, your claims will initially be placed in a pending status because we are manually reviewing all claims for accuracy. This is a temporary process to minimize denials that we will discontinue once we are confident we have identified and addressed early claims issues.

Issues with Viewing Claim Status Online

Some providers have reported their inability to view certain claims on our web portal in a timely manner. We did experience a technical error where a number of claim files were not loaded in our claim system in a timely manner. Claims that should have loaded on January 10th were not loaded until January 16th. The reason for the error has been identified and corrected. We apologize that providers were not able to see these first claims in a timely manner. Going forward, you should be able to view your claims approximately 3 days after they have been transferred to UnitedHealthcare. Please note, this did not impact any nursing facility claims. If at any time you cannot view a claim in accordance with the timeframes above, please contact your Provider Advocate and they will assist you.

Authorizations

We will continue to honor current authorizations and plans of care through the 90 day transition period. As new service needs arise, we ask all providers to seek authorization only for those services that are listed on our prior authorization list. The list can be found in Chapter 4 of our Provider Administrative Guide on www.uhccommunityplan.com.

Residential (or custodial) nursing facility stays do not require prior authorization, nor do bed holds. Post-acute nursing facility admissions meeting the Medicare guidelines do require notification if KanCare is the primary insurance. In cases where Medicare or any other plan is primary, prior authorization through UnitedHealthcare is not needed.

New service requests for home and community based services require authorization. Authorizations for these services will be provided by the member's care coordinator.

Nursing Facility Billing

The revenue codes to bill for room and board to UnitedHealthcare for KanCare members include:

101 – to be billed for Medicaid nursing facility stays
120 – to be billed for post-acute stays that meet the Medicare guidelines for skilled care

When patient liability is involved, providers should bill the full billed amount on their claim and should not reduce the billed amount by the patient liability. UnitedHealthcare will reduce the paid amount by the patient liability when we process the claim.

Provider Communications

Provider communication is critical as we work through this transition together. To facilitate communication of time sensitive information, we will communicate with you via email, continued postings on our issues log (found on www.uhccommunityplan.com) and through your Provider Advocate. If we do not have an email address on file for the appropriate contacts within your facilities and organizations, please contact your Provider Advocate.

We will also continue to post important provider information on our website at www.uhccommunityplan.com so please visit our site often. Our Provider Administrative Guide is also available at this location.

Provider Advocates

The Provider Advocates are your first contact for assistance and support. The contact information for our long term care Provider Advocate team is:

For Nursing Facilities – call 888-823-8751

- Carol Buckner is the Manager of Provider Relations for nursing facilities
- Michelle Sims is the Provider Advocate for nursing facilities.

For Home and Community Based Service Providers

- Shandy Ricketts – 316-794-2252 – Central/SE Region
- Tamara Sands – 620-227-2498 – Western Region
- Krista Hayes – 913-333-4103 – NE Region
- The HCBS Provider Territory Map is posted on our website at www.uhccommunityplan.com. Click on For Health Care Professionals at the top of the page and select Kansas from the drop down box and scroll down to the Kansas Provider Contacts section.

We are committed to working with you through this transition. Please contact us if additional information is needed or if we can assist you in any way.