Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**27**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
The bidder's Member services line receives a call from Maria, the mother of a twenty-two (22)-year-old, Hispanic, female KanCare Member named Juanita. Maria's and Juanita's primary language is Spanish. Juanita delivered a baby boy approximately two (2) weeks ago. Maria is calling out of her concern for the well-being of her daughter and grandson. Maria shares that the Member has been living temporarily with her until Juanita finds employment, transportation, childcare, and housing. Maria states while Maria works, she has been struggling to make ends meet and at times has been unable to buy groceries. Maria shares that she has recently noticed significant and increasing changes in Juanita, including bouts of crying, lack of appetite, listlessness, and frustration with caring for her baby. Maria reports that Juanita has not been sleeping much and is struggling to produce enough breast milk to meet the baby's needs. Maria thinks that the baby may be "colicky" because the baby "cries a lot" and is difficult to soothe. Maria stated that Juanita missed the first postpartum well check because the baby was finally sleeping, and Juanita did not want to wake the baby. Maria immediately called the Member services line when her daughter told her, "I can't do this anymore." Describe how the bidder will handle the call from Maria, and the bidder's approach to meeting the needs of Juanita and her baby.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.3: Covered Services	7.3.4: Value-Added Benefits
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.11: Maternity Care Coordination 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.3: Provider Network Adequacy Standards 7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care 7.5.5: Provider Network Access Standards
7.10: Member Services	7.10.1: Member Services General Requirements 7.10.10: Customer Service Center – Member Assistance

RFP References	
	7.10.11: Member Crisis Assistance 7.10.12: Member Rights and Protections
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Regarding call handling:
    i. Does the response describe how the bidder will address the caller's language assistance/translation needs?
    ii. Does the response describe how the member services representative will verify or secure authorization that allows the representative to share information about the member with the member's mother?
    iii. Does the response describe how the member services representative will handle the call and meet the member's needs if the representative cannot verify or secure authorization on the call?
    iv. Does the response describe how the bidder will assess the urgency of the member's behavioral health needs and take the appropriate actions to meet the immediate needs of the member?
    v. Does the response describe the relevant information available to the member services representative and the kind of information the representative will request from the caller to determine next steps? (Well check data, member assignment to a maternity care coordinator [low or high risk], etc.)
    vi. Does the response describe how the member service representative will provide a warm transfer the caller to care coordination?
4. Regarding meeting the needs of the member and her baby:
    i. Does the response describe how the bidder will complete or update the member's/baby's health screen, health risk assessment, and needs assessment?
    ii. Does the response describe how the bidder will ensure the member's/baby's immediate needs are met?
    iii. Does the response describe how the bidder will ensure the assigned level of care coordination aligns with the member's presenting needs (i.e., high-risk maternity due to SDOH and symptoms of postpartum depression)?
    iv. Does the response describe how the bidder will engage the member in care coordination (e.g., in person visit, offering member incentives for participating in perinatal care or well visits, use of a Spanish speaking CHW or doula located in the member's community to perform outreach activities)?
    v. Does the response describe how the bidder will meet the member's cultural and linguistic needs (e.g., care coordination system that identifies the member's needs and preferences, care coordinator and other care coordination staff that speak Spanish)?
    vi. Does the response describe how the bidder will ensure the involvement of the MCO, the member's PCP, specialists, and other providers involved in the member's care in the development of the plan of service (POS) and provision of treatment?
    vii. Does the response describe how the bidder's care coordinator will ensure the development of a POS that identifies and addresses the member's assessed physical health (e.g., postpartum care and support, breast pump, breastfeeding information), behavioral health (maternal depression screening, CCBHC

Response Considerations
referral, behavioral health assessment, crisis service resources), and SDOH needs (e.g., transportation, food insecurity/referral to WIC, employment, financial support, childcare, and housing), as well as gaps in care (i.e., missed well visit appointments)?
viii. Does the response describe how the bidder will identify and address the baby's needs (e.g., well care check and follow-up)?
ix. Does the response describe if the bidder will offer value-added services that are applicable in this case (e.g., breastfeeding education and lactation consultation; infant home visits) and how the bidder will use them to promote the member's goals in the POS?
x. Does the response describe the bidder's process for ensuring referrals to covered services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services and providers?
xi. Does the response describe how the bidder will continue to coordinate, share information, and communication with providers involved in the care of the member?
xii. Does the response describe how the bidder will continue to engage the member to consistently engage in treatment?
xiii. Does the response describe how the bidder will monitor the member's progress and ensure the POS continues to meet the member's needs, adjusting the POS as necessary?

Bidder Name	Question Number
CareSource	**27**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is excellent. • Bidder verified HIPAA to be able to speak with member's mother. • Bidder provided options such as a life coach, food pantry, 24-hour crisis line, breast pump, car seat installation, crib, and baby clothing. • Bidder provided connections including Mom and Baby Beginnings, My Family Housing Supports, Job Connect, GuidingCare, KCSL, and RCDC. • Bidder provided education on Kan Be Healthy. • Bidder discussed WIC and SNAP. • Bidder provided doula services. • Bidder provided good detail on HEDIS postpartum and prenatal QI evaluation measures. • Bidder met member within two days face-to-face. • Bidder provided immediate appointment to lactation consultant. • Bidder provided telehealth appointment with APRN the next day. • Bidder provides Luna Joy, a telehealth BH provider platform and BH benefits. • Bidder provided employment resources such as STEPS. • Bidder provided caregiver resources for member's mother. • Bidder discussed transportation VAB. • Bidder invested $108K for a state-wide housing locator tool. • Bidder provided a single point of contact for care coordination. • Bidder provided a 24/7 access to CareSource 24 which provided connections to behavioral health supports and care coordination.	Weaknesses were identified that can be easily overcome. • Bidder did not mention connecting member with a reliable cellphone. • Bidder created a person-centered care plan, but in the plan, it states "her" not "my". • It is important that all individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services and supports. • Bidder could have gone into greater detail about care for the baby including information related to member's concerns expressed on initial phone call. • Bidder did not indicate SMART goals.

- Bidder provides access to a care portal to connect member for community resources.
- Bidder identified assessment tool, Edinburgh Postnatal Depression Scale
- Bidder developed crisis plan.
- Bidder provided Spanish option upon member calling in.
- Bidder made a warm transfer to member's previous care coordinator when potential crisis was identified.
- Bidder worked in conjunction with member's mother for scheduling of appointments.
- Bidder connected member to Genesis Family Health for PH and BH services.
- Bidder indicated that member's care coordinator had 14-years of maternity experience and was Spanish speaking.
- Bidder indicated person-centered planning via MyLife platform.

General Notes

Rating

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Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**28**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Shanice is a twenty-three (23)-year-old, black, female KanCare Member who was brought to the Emergency Department (ED) by police due to injuries sustained during a fight with another person in a downtown homeless shelter. While her injuries do not appear to be life threatening, Shanice sustained injuries around her face and head and exhibits odd behavior. Shanice has a history of opioid use disorder, benzodiazepine use disorder, and stimulant use disorder in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features. Her drug screens at the ED are positive for opioids and benzodiazepines. Shanice has been receiving services through a CCBHC, but has been inconsistently engaged in treatment and has presented to the ED multiple times for either drug intoxication or withdrawal in the past year. She is unstably housed and lacks any form of Transportation. Tests conducted during the ED stay indicate that Shanice is pregnant. Describe the bidder's approach to addressing Shanice's needs.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.3: Covered Services	7.3.1: Covered and Non-Covered Services 7.3.4: Value-Added Benefits
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.11: Maternity Care Coordination 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.3: Provider Network Adequacy Standards 7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care

RFP References	
	7.5.5: Provider Network Access Standards 7.5.8: Behavioral Health Provider Network Standards
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 3.0: SUD Services 4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Given the member's complex behavioral health and maternal health needs, does the response describe the CCBHC's and bidder's respective care coordination roles, their communication and collaboration, and how the bidder will prevent care coordination gaps or duplication for this member?
4. Does the response describe which entity (MCO or CCBHC) will be primarily responsible for coordinating the care for this member?
5. Does the response describe how the bidder will update the health screen and HRA and ensure the completion of a comprehensive assessment of the member's physical health, maternal health, mental health conditions (schizoaffective disorder and major depression disorder with psychotic feature), and substance use disorders (opioid use disorder, benzodiazepine use disorder, and stimulant use disorder), and screening for tobacco and alcohol use/abuse?
6. Does the response identify how the bidder will ensure the appropriate level of care coordination for this member (e.g., high-risk due to pregnancy, mental health, substance use, and SDOH) and assignment to a care coordinator with the requisite qualifications?
7. Does the response describe how the bidder will engage the member to participate in care coordination?
8. Does the response describe how the bidder will identify and address the member's personal preferences, cultural needs and health disparities in health care access, services provision, and outcomes?
9. Does the response describe how the bidder will use a person-centered planning approach to assess and address the member's holistic physical health, behavioral health, and SDOH needs to develop a POS/care plan, including:
    i. Using the comprehensive assessment to drive the development of the POS/care plan;
    ii. Ensuring the involvement of a multidisciplinary team (medical, obstetrical, psychiatric, and addiction treatment professionals) and representation of the MCO, CCBHC, and other providers involved in the member's care in the development of the POS/care plan and provision of treatment;
    iii. Addressing follow-up care for the member's physical injuries sustained in the altercation and any other physical health needs;
    iv. Ensuring an appropriate alternative for meeting the member's housing needs other than returning the member to the street;
    v. Identifying and addressing barriers to the member's engagement in her care;
    vi. Informing and educating the member about the complexity of her conditions and the need for follow-up assessments, care planning, and care;
    vii. Using evidence-based treatment approaches to guide the member's treatment for substance abuse disorders to balance the risks and benefits to optimize maternal and infant health (e.g., residential treatment, medication-assisted treatment [MAT] for opioid use disorder, treatment programs specializing in the care of pregnant women with addictions, participation in treatment for other substance use disorders, substance abuse counseling, social supports);

Response Considerations
viii. Re-evaluating and updating the treatment for the member's mental health conditions, including the management of possible drug interactions with pharmacotherapies during the course of the pregnancy; ix. Identifying and addressing the member's SDOH needs, including assistance with obtaining housing, nutritional food, transportation, and employment; x. Offering value-added services to the member (e.g., doulas, peer support, maternal home visits, contingency management); xi. Addressing the member's prenatal care needs (e.g., supporting the member to select an OB-GYN, assisting with scheduling prenatal appointments, access to prenatal vitamins); and xii. Providing member prenatal education (one to one education, birthing and parenting classes, breastfeeding, neonatal abstinence syndrome)? 10. Does the response describe the bidder's process for ensuring referrals to covered services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services and providers? 11. Does the response describe how the bidder will continue to coordinate, share information, and communication with the CCBHC and other providers involved in the care of the member? 12. Does the response describe how the bidder will continue to engage the member to consistently engage in treatment? 13. Does the response describe how the bidder will monitor the member's progress and ensure the POS/care plan continues to meet the member's needs, adjusting the POS/care plan as necessary?

Bidder Name	Question Number
CareSource	**28**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is excellent. • Bidder indicated CT scan and medical tests for injuries. • Bidder indicated MAT consideration. • Bidder indicated assigned care coordinator who has 10-years of experience in obstetrics nursing and BH. • Bidder indicates meeting with member the next day in person. • Bidder indicates NEMT for transportation needs, as well as coordination with driver through an app. • Bidder indicates VAB cellphone and internet service. • Bidder indicates CareSource life coach. • Bidder indicates MyLife app as an informed choice. • Bidder connected member with a doula. • Bidder indicates care portal, and VAB for crib and car seat as options. • Bidder indicates CareSource 24, 24/7 nurse advice BH line. • Bidder indicates connection with certified peer specialist. • Bidder provided a 72-hour hold for psych observation. • Bidder identified names of assessment tools. • Bidder referred for the completion of a coordinated entry assessment. • Bidder provided training for NARCAN. • Bidder provided detailed journey diagram. • Bidder provided referral to Vibrant Health. • Bidder is able to receive alerts when member shows up at ED. • Bidder completed HRA and behavioral health assessment.	Weaknesses were identified that can be easily overcome. • Bidder did not indicate SMART goals. • Bidder lacked follow up on any pending charges related to the altercation at the homeless shelter. • Bidder created a person-centered care plan, but in the plan, it states “her” not “my”. • Bidder did not detail how they would assess member with employment concerns during initial planning. • Bidder did not connect member with CHW. • Bidder did not demonstrate understanding of doula benefit coverage in Kansas and depended on in lieu of services (ILOS). • Bidder did not verify there were birth control conversations with member.

- Bidder ensured member choice throughout the process.
- Bidder provided information/connection regarding Mom and Baby Beginnings program.
- Bidder is well aware of pregnancy risks and disparities and communicated those risks and disparities to the member.
- Bidder showed knowledge of housing crisis response system.
- Bidder provided the care coordination supports and resources that enabled the member to be hired as a CNA for Vibrant Health.
- Bidder ensured there was pediatrician coverage prior to delivery.

General Notes

Rating

5

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**29**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Robert is a twenty-five (25)-year-old, white, male KanCare Member with Cerebral Palsy enrolled in the IDD HCBS Waiver. He is currently being treated in an acute care hospital for an upper respiratory infection and is nearing discharge. In addition to having a limited ability to meet his basic personal care needs, Robert is wheelchair dependent and requires an augmentative communication device. Robert is currently living with his grandmother, Betty, who has been providing the majority of support for his personal care needs. Betty recently learned that she has stage 4 rectal cancer and is gravely concerned about her ability to continue to care for Robert when he is discharged, and anxious about who will take care of him when she dies. There are no additional family supports for Robert. Robert is very intelligent and close to getting a bachelor's degree in computer programming. He would like to live independently, complete his schooling, and obtain employment. Describe the bidder's approach to supporting the hospital discharge planning process and to initiating and managing Robert's follow-up care to assist him in meeting his short- and long-term needs and personal goals upon discharge.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.3: Covered Services	7.3.1: Covered and Non-Covered Services 7.3.2: Work Opportunities Reward Kansans (WORK) Program 7.3.3: Supports and Training for Employing People Successfully (STEPS) 7.3.4: Value-Added Benefits 7.3.5: In Lieu of Services
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System

RFP References	
7.5: Provider Network	7.5.3: Provider Network Adequacy Standards 7.5.5: Provider Network Access Standards 7.5.7: Long-Term Services and Supports Provider Network Standards
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 5.0: HCBS
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response describe the respective roles and responsibilities and the communication and collaboration between the MCO care coordinator, the targeted case manager (TCM), and the community developmental disability organization (CDDO) related to the provision of care coordination for the member?
4. Does the response describe how the bidder will consider the current needs and preferences of the member to provide the appropriate level of care coordination and assignment to a qualified care coordinator?
5. Does the response describe how the bidder will support the development of a transition plan/discharge plan that identifies and addresses the member's holistic physical health, behavioral health, and SDOH needs, such as:
    i. Updating the member's needs assessment based upon his condition and circumstances;
    ii. Including the member, grandmother, inpatient hospital, MCO care coordinator and TCM in the development of the transition/discharge plan;
    iii. Identifying the need for any additional services and supports to prevent readmission/future respiratory infections?
    iv. Determining the member's grandmother's ability and willingness to care for the member upon discharge, as well as any limitations;
    v. Identifying the need for any additional in-home services and supports necessary (e.g., overnight respite, home health, personal care services);
    vi. Identifying the need for any additional equipment or supply needs for the member's wheelchair or augmentative communication device;
    vii. Arranging for any respiratory care equipment ordered by the inpatient team (e.g., suctioning devices, oxygen, etc.);
    viii. Scheduling aftercare appointments (e.g., respiratory specialist, PCP);
    ix. Identifying the need for a personal emergency response system, installation and instructions, given the caregiver's health status;
    x. Identifying the need for a mental health assessment, given grandmother's decline and likely terminal condition;
    xi. Identifying the member's SDOH needs (e.g., non-covered transportation, housing, education); and
    xii. Developing an individualized back-up plan and a disaster/emergency plan?
6. Does the response describe how the bidder will ensure the discharge/transition plan is incorporated in the member's PCSP and that necessary signatures are obtained?
7. Does the response describe how the bidder will ensure that the services specified in the discharge/transition plan are secured, and that the transition occurs with minimal service and provider disruption to the extent possible?

Response Considerations
8. Does the response describe how the bidder will ensure transition-related coordination and communication between the member's primary care provider and specialists? 9. Does the response describe how the bidder will ensure follow-up with the member and member's providers to ensure post discharge services have been provided? 10. Does the response describe coordination and planning between the MCO care coordinator, TCM, CDDO, HCBS providers, primary care provider, and specialists to address the member's longer-term personal health goals in the member's PCSP, such as: i. Discussing the member's goals in more detail to understand his preferences (e.g., living arrangements, education, employment); ii. Identifying other goals related to achieving independence (e.g., cooking, daily living skills, ability to use public transportation); iii. Identifying the services and supports the member needs to assist him in achieving his goals; iv. Educating the member about self-direction, the Working Healthy/WORK program, STEPS, supported employment services, and other employment programs options and assisting with referrals; v. Identifying whether the member needs assistance with managing his finances or financial planning; vi. Supporting the member's continued education and employment goals; and vii. Identifying the need for social supports and activities? 11. Does the response describe the bidder's process for ensuring timely referrals to covered supports and services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services, supports, and providers? 12. Does the response describe how the bidder will continue to coordinate, share information, and communication with the TCM, CDDO, HCBS providers, primary care provider, specialists, and other providers involved in the care of the member? 13. Does the response describe how the bidder will monitor the member's progress to ensure the PCSP is effective in meeting the member's health care needs and achieve his health goals, adjusting the PCSP as necessary?

Bidder Name	Question Number
CareSource	**29**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
• Bidder documented CareSource journey effectively. • Bidder indicated they receive alerts for hospital admissions via KHIN. • Bidder updated HST and HRA. • Bidder identified service and DME needs member would have when he returned home. • Bidder gave training to their care coordinators on common health issues, such as aspiration and sepsis. • Bidder indicated that member's augmentative communication device was malfunctioning and was aware of ATK as a resource for repair. • Bidder indicated awareness of Cerebral Palsy Foundation and wheelchair seating clinic. • Bidder understood need for an increase in personal care support because his grandmother had been in that role. • Bidder recognized need for home delivered meals as well as personal emergency response system (PERS). • Bidder reviewed member safety plan. • Bidder educated member about potential telemedicine options. • Bidder connected member with CCBHC for potential need for grief counseling and social connections. • Bidder indicates involvement in the Kansas Employment First Grant Pilot. • Bidder educated member on ABLE account.	The response is minimally acceptable. • Bidder's housing option may have been unrealistic; there were not multiple options provided or discussed. Bidder's housing plan did not provide connection to resources such as federal financial subsidies that he may be entitled to. • Bidder could have provided more detail around financial planning services, ADL support beyond PCS, and WORK/Working Healthy. • Bidder did not indicate SMART goals. • Bidder did not indicate how the home delivered meals were provided. • Bidder did not reference CDDO for options counseling and affiliated providers. • Bidder did not clearly indicate informed choice. • Bidder indicates conflict of interest for provider usage but does not address that OCCK is member of INTERHAB, which is member of their health alliance. While acknowledgment of TCM conflict is mentioned, there is not mitigation of the conflict. • Bidder created a person-centered care plan, but in the plan, it states "his" not "my". • Bidder did not provide a housing sustainability plan, even though he said he was going to live with his grandmother. No discussion regarding if member would be able to continue to live in the home after his grandmother's passing. • Bidder identified state organization, Department of Social and Rehabilitation Services (DSRS), that is no longer in existence.

- Bidder connected member's grandmother to Future Is Now program as caregiving support.
- Bidder encouraged member to be involved with Kansas Council on Developmental Disabilities. Bidder provided self-determination education and advocacy contacts through the self-determination inventory: adult report (SDI:AR) assessment.
- Bidder connected member to iLink which is a VAB with GoodLife innovations for personal security and remote tech support.
- Bidder assigned IDD care coordinator specifically trained in IDD and CareSource's Transition of Care model.
- Bidder indicated IDD TCM as point of contact upon discharge.
- Bidder indicated evaluation and referral for a pulsating vest. Bidder confirmed evaluation for pulmonary rehabilitation.
- Bidder confirmed evaluation for gastroesophageal reflux disease (GERD).
- Bidder provided member opportunity to tour housing option.
- Bidder's case scenario indicated discharge planning at time of admission.
- Bidder provided polypharmacy review.
- Bidder's person-centered care plan included MyLife and NCQA attainment scale.

- Bidder did not provide information on agency direct services.
- Bidder did not have a discussion with member and grandmother and/or provide grandmother information on advanced planning for end-of-life outcomes impacting member.
- Bidder mentions referring to a seating clinic. There was no follow-up, outcome, nor timeframe provided for the seating clinic referral.
- Bidder did not provide information on back up plan.
- It is important that all eligible individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services and supports including a housing specialist.

General Notes

Rating

2

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**30**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Billy is a thirty (30)-year-old, white, male KanCare Member currently residing in a skilled NF as a result of injuries sustained in an automobile accident, including a traumatic brain injury. Billy has been living in the skilled nursing facility (NF) for the last 14 months. Billy receives physical and speech therapies but continues to struggle with slurred speech, coordination, and balance. He is eager to move back into his home, eventually go back to work, and "get his life back". Billy recognizes that he may still need assistance in order to manage basic needs in his home, but finds being in a "nursing home" is depressing and lonely. In addition to his physical and speech challenges, Billy is overweight and developed a stage 3 pressure ulcer. He also experiences periodic incontinence. Describe how the bidder will assist Billy in planning for and implementing Billy's transition, including monitoring post-transition and assisting him to achieve his personal goals.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with other agencies
7.3: Covered Services	7.3.1: Covered and Non-Covered Services 7.3.3: Supports and Training for Employing People Successfully (STEPS) 7.3.4: Value-Added Benefits 7.3.5: In Lieu of Services
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.3: Long-Term Services and Supports Functional Eligibility Determinations 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified populations 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.3: Provider Network Adequacy Standards 7.5.5: Provider Network Access Standards 7.5.7: Long-Term Services and Supports Provider Network Standards 7.5.8: Behavioral Health Provider Network Standards

RFP References	
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 4.0: Mental Health Services 5.0: HCBS
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response address how the bidder will update the health screen, health risk assessment, and needs assessments?
4. Does the response address how the bidder will complete a comprehensive whole-person assessment that includes identification of the member's health goals, strengths and challenges that will be used in development of the member's POS?
5. Does the response describe an appropriate level of care coordination to meet the needs of this member?
6. Does the response describe the assignment of an MCO care coordinator with the requisite long term care experience working with individuals like the member?
7. Does the response describe how the bidders will identify and coordinate with any Medicare care manager, if the member is also Medicare eligible?
8. Does the response describe how the bidder will initiate and engage the member, skilled NF, other care coordinators, and other providers in discharge planning and institutional transition processes?
9. Does the response describe how the bidder will support the development of a discharge/transition plan that identifies and addresses the member's holistic physical health, behavioral health, and SDOH needs to meet his personal health goals, such as:
    i. Referring the member to determine his eligibility for BI HCBS waiver;
    ii. Assisting the member to apply for an institutional transition and evaluating the member's eligibility for Money Follows the Person;
    iii. Determining whether self-directed care is an option and preferred by the member;
    iv. Educating the member about the STEPS program and assisting with referrals for eligibility;
    v. Identifying the services necessary to meet the member's physical health care needs (e.g., medical equipment and supplies; if in BI waiver, home modification and assistive technology);
    vi. Coordinating with the member's primary care provider and specialists to address the member's pressure ulcer upon discharge (e.g., home health care for nursing, weight management plan, skin integrity care plan) and incontinence;
    vii. Identifying necessary in-home supports (e.g., if in BI waiver, home health, personal care services, transitional living skills, home delivered meals);
    viii. Identifying the need for medication reminder services and/or personal emergency response system installation if in BI waiver;
    ix. Arranging for the continuation of rehabilitation therapies, including PT, ST, OT, and cognitive rehabilitation;
    x. Assessing and addressing the member's behavioral health needs;
    xi. Identifying and assisting the member to address SDOH needs (assistance with transportation, social supports);
    xii. Identifying supports needed for managing finances to maintain Medicaid eligibility (e.g., injury settlement, spend down); and
    xiii. Documenting the discharge/transition plan in the member's POS or PCSP (if on a BI waiver) and obtaining the necessary signatures?

Response Considerations
10. Does the response describe coordination and planning between the MCO care coordinator (as well as the community care coordinator involved in the member's care), HCBS providers (if on a BI waiver), community-based primary care provider, and specialists to address the member's longer-term personal health goals in the member's POS/PCSP, such as: i. Discussing the member's long-term goals in more detail (e.g., return to work): ii. Identifying other goals related to regaining his independence (e.g., cooking, daily living skills); iii. Identifying the member's need for social supports and activities; and iv. Identifying the services and supports the member needs to assist him in achieving his goals? 11. Does the response describe how the bidder will provide referrals for as identified in the POS/PCSP? 12. Does the response describe how the bidder will ensure referrals for covered services, non-covered services, and community resources and timely authorization of services identified in the POS/PCSP? 13. Does the response describe how the bidder will monitor to ensure the member's access to the services and support in the POS/PCSP? 14. Does the response describe how the bidder will monitor to ensure the member's progress and that the POS/PCSP is effective in meeting the member's health care needs and achieve his health goals, adjusting the POS/PCSP as necessary? 15. Does the response describe how the bidder will coordinate, share information, and communicate with the NF, specialists, primary care, and other providers involved in the care of the member throughout the transition and post-transition time period?

Bidder Name	Question Number
CareSource	**30**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder indicated nurse care coordinator was assigned. • Bidder indicated GuidingCare platform notified at nursing facility admission. • Bidder indicated in-person visit to perform HRA and other assessments. • Bidder indicated stratification of level III risk for member. • Bidder indicates referral to BI waiver. • Bidder indicated renvac training for in home use. • Bidder indicated Medicaid and non-Medicaid resources were discussed to meet needs. • Bidder indicated home health and personal care service provider options were provided. • Bidder identified waiver services that would benefit member including PTST and BT. • Bidder discussed exercise and weight-loss. • Bidder discussed employment via Job Connect. • Bidder's nurse read minimum data set end title to assess for needs prior to admission. • Bidder's NDS data use aligns with state data collection efforts. • Bidder held an in-person visit prior to discharge to assess for home modification needs and safety. • Bidder held day of discharge face to face support. • Bidder indicates history between 2020 and 2022 of increasing by 17% people discharging form NF to community settings.	Weaknesses were identified that can be easily overcome. • Bidder did not indicate SMART goals. • Bidder did not indicate timeliness of BI waiver document sent in order to access institutional transition. • Bidder discusses setting up HCBS services prior to HCBS approval. • Bidder does not discuss institutional transition process in response, which would lead to a delay in coding for the member and cause a delay in services. The referral for BI waiver was sent to ADRC rather than following state institutional transition policy. • Bidder indicates "BI waiver covers any additional home mod expenses" there is a $7500 maximum for BI waiver home modifications. There is no discussion on limits nor what would occur if modifications were to exceed that amount. • Bidder did not discuss WORK/Working Healthy with the member, nor did they discuss what employment could do to Medicaid coverage including termination or spend down. • Bidder created a person-centered care plan, but in the plan, it states "his" not "my". • Bidder does not identify how the care coordinator team safely identifies members for return to community. • It is important that all eligible individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services and supports including a housing specialist. In addition, there was no attempt or documentation to

- Bidder's CareSource journal table descriptive and easy to read.
- Bidder informed member of potential for the use of vehicle modification, ATK and other DME.
- Bidder connected with member the following day.
- Bidder established post-acute care team (PACT) focused solely on transitions from skill nursing facilities, etc.
- Bidder connected member with a life coach.
- Bidder connected member's caregiver with caregiving supports.

identify referrals to federal housing subsidies that member and wife may be eligible for to sustain residing independently in the community.

- Bidder's response did not include reporting of member's pressure ulcer, which should have been reported as a potential NF quality of care issue deserving of follow-up.
- Bidder uses ILOS frequently and inappropriately. Bidder does not demonstrate understanding of the hierarchy of funding measures in Kansas.
- While bidder referred to ATK for vehicle modification and DME, bidder does not indicate follow-up, outcomes, nor timeframe provided for vehicle modification. Bidder did not indicate funding stream and if this would be part of home modification funds. Bidder indicated ATK can provide communication and mobility tools but did not provide specifics that could or would be utilized by this member.

General Notes

Rating

3

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**31**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Mary is a twenty-eight (28)-year-old, white, female who is incarcerated at a correctional facility serving a two (2) year sentence for a felony conviction. Her estimated release date is in two (2) weeks. Prior to her incarceration, Mary was enrolled in KanCare; however, her KanCare enrollment was suspended upon incarceration. Mary will be a Member of the bidder's plan upon release. Mary has a history of schizoaffective disorder and substance use (marijuana and alcohol). She has been receiving medication for her mental health condition (Abilify and Depakote) throughout her incarceration, but has not received treatment for substance use. Mary does not believe she has had or has a problem with substance abuse, though her prior usage led to her inability to maintain employment and housing. Mary has "burned bridges" with her family and friends and will not have a place to live upon her release. She is, however, optimistic about her future and is willing to do "whatever it takes" to get back on track. Describe the bidder's approach to planning for and addressing Mary's needs to support her successful re-entry into the community.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.2: Network Development 7.5.3: Provider Network Adequacy Standards 7.5.5: Provider Network Access Standards 7.5.8: Behavioral Health Provider Network Standards
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	3.0: SUD Services

RFP References	
	4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response describe the challenges the member will face upon release, such as:
    i. A short supply of medications and delays in accessing post-release appointments and resources;
    ii. Pressing SDOH needs (e.g., housing, food, transportation, employment, social supports);
    iii. The member's legal status (felon) and potential impact on employment and housing options;
    iv. Limited pre-release planning; and
    v. Communication barriers in the absence of a phone or known physical location of the member?
4. Does the response describe the bidder's approaches to supporting the needs of this member as she transitions out of prison and into the community, such as:
    i. Ensuring timely reinstatement of Medicaid enrollment;
    ii. Partnering with the prison to coordinate and prepare for the member's transition;
    iii. Obtaining health records from the prison and justice system providers;
    iv. Performing a health screen and health risk assessment;
    v. Assistance with accessing medications prescribed and required post-release; and
    vi. Connecting the member to a CCBHC for ongoing care coordination and behavioral health services?
5. Does the response describe how the bidder will ensure the CCBHC identifies and addresses the member's holistic physical health, behavioral health, and SDOH needs, including:
    i. Using strategies to outreach and engagement the member post-release, including the use of peer support or CHWs as needed;
    ii. Performing a comprehensive needs assessment, including an assessment of the member's mental health condition and substance use;
    iii. Determining and assigning the appropriate level of care coordination;
    iv. Developing a person-centered planning approach with an interdisciplinary team to develop a POS/care plan the addresses the member's holistic physical health, behavioral health (schizoaffective disorder and marijuana and alcohol use), and SDOH needs (assistance accessing housing, food, transportation, employment, social supports);
    v. Providing referrals for covered services, non-covered services, and community resources as identified in the POS/care plan;
    vi. Ensuring timely authorization of needed services; and
    vii. Monitoring to ensure the member's access to the services and supports in the POS/care plan and achievement of member's personal health goals?
6. Does the response describe how the bidder will coordinate, share information, and communicate with the CCBHC and other providers involved in the care of the member?
7. Does the response describe the respective care coordination roles and responsibilities of the MCO and CCBHC to avoid care coordination gaps and duplication?

Response Considerations
8. Does the response describe how the bidder will monitor to ensure the POS/care plan continues to meet the member's needs, and ensure the POS/care is adjusted as necessary?

Bidder Name	Question Number
CareSource	31

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is very good. • Bidder completes assessments and thorough planning before member is released stratifying risk level to III. • Bidder connects member to peer support specialist. • Bidder recognizes member's SDOH needs. • Bidder informed the member about STEPS and WORK. • Bidder connects member to CCBHC in area-Central Kansas Mental Health Center CKMC. • Bidder connected with Kansas state reentry coordinator. • Bidder ensured that information given to the member was provided in a way to prevent her from being overwhelmed. • Bidder indicates collaboration between assigned care coordinator and CCBHC care coordinator, and Community Care Coordinator (CCC). • Bidder meets member at the correctional facility before release. • Bidder indicates services through CareSource LifeServices for housing, employment, and education supports. • Bidder indicates information on how to access SafeLink phone at release. • Bidder indicates transportation coordination via NEMT. • Bidder indicates SparkWheel and local food banks. • Bidder utilized GuidingCare platform model. • Bidder incorporated member's re-entry transition plan into person-centered healthcare.	Weaknesses were identified that can be easily overcome. • Bidder needs more exploration of substance use history. • Bidder needs more detail on financial planning and education. • Bidder did not ensure that member actually initiated her social security benefits. Therefore, member could be at risk of losing her Medicaid coverage after 90 days. • Bidder references contact with member upon enrollment; however, member is not enrolled with MCO until release. • Bidder indicated re-enrollment for Medicaid after incarceration via the KanCare website. This indicates bidders lack of familiarity with the process of connecting incarcerated individuals from KDOC upon release. • Bidder indicates connection with provider prior to release; however, KanCare will not be able to be billed prior to release. • Bidder did not provide comprehensive information regarding community resources and/or groups. • Bidder did not indicate choice of community chosen by member post release, which would have driven her CCBHC choices and all other resources. • Bidder did not indicate SMART goals. • Bidder only provided member one housing option. • Bidder did not reference a Housing Specialist. It is important that all eligible individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services

- Bidder showed good role separation and clarification in separating healthcare planning and criminal justice planning with a predictive risk modeling tool Population Risk Insights.

and supports that will assist the individual with residing independently in the community.

- Bidder described that creation of a person-centered care plan began without the member present.

General Notes

Rating

4

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**32**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Pedro is a seventeen (17)-year-old, Latino, male KanCare Member living in foster care. Pedro was diagnosed with asthma at four (4) years old and uses an inhaler to manage his symptoms, with varying success. At his last health care visit, Pedro and his foster mother shared with Pedro's Primary Care Provider (PCP) that Pedro is having more difficulty breathing and more frequent asthma attacks. When the PCP inquired about the precipitating circumstances, the PCP learned that the breathing problems and asthma attacks have been occurring when Pedro is at home — not at school or other locations, leading his PCP to think that there may be an environmental trigger in the home. Pedro has had four (4) ED visits in the last twelve (12) months due to his asthma. Pedro's case file also states he experienced significant physical and emotional abuse during his early childhood, resulting in his placement in foster care. Pedro was once active in school and extracurricular activities but recently has become more withdrawn, leading his foster parents to suspect marijuana or other substance use, which they have expressed to his PCP. Pedro's PCP has contacted the bidder's Care Coordination team to request assistance with assessing and addressing the potential environmental trigger exacerbating Pedro's asthma, and to make the care coordinator aware of Pedro's possible behavioral needs. Describe how the bidder will respond to the PCP's request and how the bidder will support and coordinate Pedro's health needs.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.9: Care Coordination Training Requirements 7.4.10: Requirements for Specified Populations 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.2: Network Development 7.5.3: Provider Network Adequacy Standards

RFP References	
	7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care 7.5.5: Provider Network Access Standards 7.5.8: Behavioral Health Provider Network Standards
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 3.0: SUD Services 4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response describe how the bidder will respond to and connect the PCP to the member's assigned care coordinator?
4. Regarding the bidder's approach to supporting and coordinating the member's health needs:
    i. Does the response address the member's enrollment in care coordination as a youth in foster care?
    ii. Does the response describe an approach that addresses the member's cultural and linguistic needs and is trauma-informed?
    iii. Does the response describe the assignment of an MCO care coordinator with the requisite education, experience (working with children in foster care and multi-system children), and training (including trauma-informed care)?
    iv. Does the response address how the bidder will update the health risk assessment and needs assessments, based upon the changes to the member's condition and needs?
    v. Does the response describe how the bidder will hold interdisciplinary team meetings (consisting of at a minimum the member, foster parent, MCO care coordinator, any community-based care coordinator, the foster care case management provider, the child welfare management worker, the PCP and any other treatment providers to engage in person-centered service planning process for the development and implementation of the Plan of Service (POS) or care plan (if receiving services from a CCBHC)?
    vi. Does the response describe how the bidder will communicate and collaborate with the PCP, CCBHC (when involved), and other treatment team members to develop a strategy to assess what may be triggering the member's asthma attacks (e.g., collecting additional information about the circumstances surrounding asthma attacks, allergy testing, home assessment to identify potential allergens or irritants such as pet hair/dander, second-hand smoke, pests, mold, chemical products, and dust)?
    vii. Does the response describe the development of a POS/care plan that identifies and addresses the member's holistic care needs (physical [e.g., asthma], behavioral health [e.g., the need for specialty providers to address abuse history, a CCBHC assessment of the behavioral health needs of the member and provision of CCBHC services if necessary], and SDOH [ameliorating conditions in the home that are triggering asthma attacks, coordination with school, identifying opportunities for extra-curricular activities])?

Response Considerations
viii. Does the response describe how the bidder considers and addresses that the member is a transition-aged youth who will soon be transitioning from various child-serving systems in the care planning process (educational goals; employment preparation and support; living arrangements and independent living skills; financial knowledge; social connections; transitions from pediatric providers to adult providers)?
ix. Does the response describe how the bidder will handle the potential transition of care coordination to the CCBHC?
x. Does the response describe the bidder's process for ensuring referrals to covered services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services and providers?
xi. Does the response describe how the bidder will monitor to ensure the POS/care plan is meeting the member's identified needs, adjusting the POS/care plan as necessary?

Bidder Name	Question Number
CareSource	32

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is very good. • Bidder connected member with LifeServices program. • Bidder connected member with MyFamily Guiding Principles. The response indicates this program is a holistic model of care for foster and at-risk youth. • Bidder indicated they had a foster care liaison. • Bidder connected with FQHC, Community Health Center of Southeast Kansas. • Bidder made a Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment, outcome pending. • Bidder indicated discussions on job future and education. • Bidder updated HRA. • Bidder connected member to pulmonologist. • CCBHC did BH assessment, trauma child and adolescent need assessment. • Bidder discussed VAB through YMCA. • Bidder connected member w DCF independent living program. • Bidder updated PCSP with short term and long-term goals. • Bidder connected to BeMe health app. • Bidder identified MCO care coordinator as the lead. • Bidder indicated peer support specialist coordination. • Bidder indicated Community Connections Youth Thrive via Foster Adopt Connect, which is a transition to adulthood resource.	Weaknesses were identified that can be easily overcome. • Bidder did not adequately address foster care parents concern regarding member's potential substance use. • Bidder did not adequately coordinate with school. • Bidder did not adequately showcase cultural competency. • Bidder did not indicate SMART goals. • Bidder did not indicate use of Kan Be Healthy or EPSDT. • Bidder created a person-centered care plan, but in the plan, it states "his" not "my". • Bidder indicates $100 gift card for membership. This is above CMS limit. • Bidder does not indicate discussion of prior frequent ED visits.

- Bidder identified Connect Our Kids, which is a program coordinated with CMP to reconnect member to his biological family.
- Bidder indicated “teach back” method for verification that member knew how to take his medicine.
- Bidder indicated that they used Strengthening Families as evidence-based framework.
- Bidder provided connection to CHW through CHCSEK.
- Bidder provides caregiver connect for family support caregiving needs.
- Bidder utilized a Life Coach.
- Bidder identified specific assessment and treatment tools.
- Bidder’s CareSource journey table was clear, easy to follow, and concise.

General Notes

Rating

4

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**33**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Henry is a twelve (12)-year-old, white, male KanCare Member who has complex medical needs, including significant IDDs with co-occurring severe behavioral health issues. In recent months, Henry has become increasingly aggressive towards other people and the family pet, with behavioral episodes that are both more frequent and more severe. These episodes have resulted in repeated crisis interventions, visits to the hospital ED, inpatient psychiatric stays, and calls to law enforcement. Henry's most recent episode of aggression resulted in his current stay in a psychiatric hospital. Henry's mother, Shauna, is a single parent to Henry and his two (2) younger siblings, a brother who is eight (8) and a sister who is five (5). Shauna has been very involved in and supportive of Henry's treatment. While Henry has not harmed his siblings to date, his increasing aggression has left her afraid both for her own safety and the safety of her other children. As part of the planning for Henry's discharge from inpatient psychiatric care, Shauna requested residential treatment for Henry to stabilize his behavioral health condition and work on managing his aggressive behaviors before Henry is returned to her home. The team involved in Henry's discharge planning is encountering difficulties in identifying an appropriate and available placement option to meet Henry's IDD and behavioral health needs. The inpatient facility is pressing for the Member's discharge and has suggested intensifying outpatient services until a suitable placement is available. Shauna has stated that while she wishes things were different, she is unable to allow Henry to return home in his current condition — that the threats to the safety of the family have grown to an unacceptable level, and that if forced, she will request that he be placed in state custody. Describe the bidder's approach for addressing the Member's discharge needs, including how the bidder will support care planning and transitions to meet Shauna's goal of having Henry return home to his family.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System

RFP References	
7.5: Provider Network	7.5.2: Network Development 7.5.3: Provider Network Adequacy Standards 7.5.5: Provider Network Access Standards 7.5.7: Long-Term Services and Supports Provider Network Standards 7.5.8: Behavioral Health Provider Network Standards 7.5.10: Non-Participating Providers
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 4.0: Mental Health Services 5.0: HCBS
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response align with KanCare's care coordination goals and objectives?
4. Does the response describe the bidder's actions taken to confirm the member's IDD or SED HCBS Waiver enrollment or waiting list status or to assist the member/family to connect with an appropriate assessing entity for determination of eligibility for HCBS waiver programs or SED diagnosis?
5. Regarding discharge/transition planning:
    i. Does the response describe an appropriate level of care coordination and the assignment of an MCO care coordinator with experience working with IDD/SED populations?
    ii. Does the response describe how the bidder will engage the member and his mother in care coordination, discharge, and transition planning?
    iii. Does the response describe how the bidder will work with the psychiatric hospital to assess the member's current physical health, behavioral health, and SDOH needs (e.g., physical health concerns, changes to medication regimen, behavioral management needs, assessment of risk, family resources, family counseling)?
    iv. Does the response describe how the bidder will update the member's health risk assessment and needs assessment, including a home safety risk assessment, and incorporate the discharge/transition plan and services into the member's PCSP/care plan?
    v. Does the response describe the communication and coordination between the MCO care coordinator and targeted case manager and/or CCBHC to support discharge/transition planning and implementation?
    vi. Does the response describe how the bidder will use a person-centered planning approach to engage the hospital and the member, family, targeted case manager and/or CCBHC, and other providers involved in the member's care to develop a discharge/transition plan, including documenting signatures from each team member?

Response Considerations
vii. Does the response describe how the bidder will work with the discharge/transition planning team to evaluate discharge options and settings (e.g., specialty PRTF, residential placement with supplemental services to meet the member's needs, qualified non-participating provider options, intensive outpatient services, behavioral health crisis planning and resources, referral to a CCBHC) to address the member's shorter team needs? viii. Does the response describe how the bidder will provide alternatives to relinquishing custody to the member's mother and offer treatment options and resources that address her concerns about the safety of the family? ix. Does the response describe the bidder's process for ensuring referrals to covered services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services and providers? 6. Does the response describe the bidder's approach to longer term planning and goals to support the member's return to home, such as: i. Arranging for family visits, family counseling, home visit and supports, and developing a return to home plan while the member is in residential treatment (if the member is in residential treatment following discharge); and ii. Arranging for in home supports, respite services, and crisis planning when the member returns to the home? 7. Does the response describe how the bidder will monitor the member's progress and ensure the PCSP/care plan is meeting the member's needs, adjusting the PCSP/care plan as necessary?

Bidder Name	Question Number
CareSource	33

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder discussed potential for SED waiver. • Bidder discussed OASIS and ABA. • Bidder provided information regarding Safe Families for Children (SFFC). • Bidder provided information regarding caregiver supports. Bidder connected parents to Circle of Parents Program. • Bidder completed HRA and SDOH needs assessment. • Bidder developed a crisis and safety plan with resources. • Bidder provided detailed approach of ICT to develop a targeted functional behavior plan. • Bidder indicated discharge planning at admission. • Bidder indicated Functional Behavioral Assessment (FBA) via the Rainbow's Behavior Specialist was completed prior to discharge. • Bidder indicated MCO care coordinator assigned was a CS Complex Care Coordinator. • Bidder indicated that the IDD TCM at Rainbows was the lead coordinator prior to SED waiver exploration. • Bidder's care coordinator recommends the use of intensive outpatient services before residential placement. • Bidder used provider plans to prevent duplication of screening and assessments. • Bidder utilized GuidingCare platform.	Weaknesses were identified that can be easily overcome. • Bidder started looking for PRTF without initiating PRTF process or approval. • Bidder gave unrealistic 7-day timeframe for SED waiver approval. • Bidder did not mention services via EPSDT, PCS/attendant care and did not reference screening for vaccinations. • Bidder did not provide enough detail on care options. • While bidder provided caregiver support information, no discussion or information provided for supports for other children in the home. • Bidder did not describe a home safety risk assessment. • Bidder indicates SED waiver has supportive home care and enhanced care services, but neither are listed SED waiver services. • Bidder did not indicate referral to Parson's DTTS team although Henry had a history of crisis, law enforcement interaction, and inpatient psychiatric stays. • Bidder did not indicate SMART goals. • Bidder did not describe St. Francis intensive in-home treatment. • Bidder indicated IDD TCM takes the lead, but SED waiver was applied, so the SED TCM would take lead. Bidder does indicate an SED Care Coordinator with the CCBHC, however, this would be provided by the Bidder. • Bidder created a person-centered care plan, but in the plan, it states "his" not "my".

	• Bidder indicated member is already on IDD waitlist but does not provide what potential supports/interventions have been in place while on the waitlist.

General Notes

Rating

3

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**34**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Alice is a three (3)-year-old, white, female KanCare Member who lives in Holcomb and was referred by her pediatrician to a developmental pediatrician for further assessment. Alice is an only child. She started using words at 16 months of age, but her use of language has regressed. She communicates primarily using hand and body gestures. In order to provide an opportunity for social engagement, Alice's parents enrolled Alice in day care. Alice attends day care three (3) days out of the week for four (4) hours per day. Contrary to Alice's parents' intentions, daycare staff report Alice isolates from and is unable to effectively communicate with other children and staff. Staff also report Alice engaged in head banging and hand flapping when they tried to engage her in activities. Alice was assessed by the developmental pediatrician as being at risk for autism. The developmental pediatrician recommends Applied Behavior Analysis (ABA) therapy for Alice, specifically, early intensive behavioral intervention. The developmental pediatrician's office has contacted the bidder's Provider services line to assist with locating a Provider because the coordinator was unable to find an ABA therapist within a reasonable distance from the Member and her family. Describe the process the bidder will follow to respond to the Provider's call and assist the Member and her family to ensure adequate and timely access to ABA therapy services.

RFP References	
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5 2: Network Development 7.5.3: Provider Network Adequacy Standards 7.5.5: Provider Network Access Standards 7.5.8: Behavioral Health Provider Network Standards 7.5.10: Non-Participating Providers
7.6: Provider Services	7.6.5: Customer Services Center – Provider Assistance

RFP References	
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response describe how the bidder's provider services representative will respond to the provider or appropriately route the call?
4. Does the response describe how the bidder will ensure timely access to an ABA therapist and all other medically necessary services for the member?
5. Does the response describe how the bidder will:
    i. Outreach/engage the family to complete, as necessary, a health screen, health risk assessment, and needs assessments;
    ii. Ensure the assigned level of care coordination aligns with the member's presenting needs;
    iii. Assign a care coordinator with the requisite qualifications to meet the member's needs;
    iv. Outreach/engage the family to complete a comprehensive evaluation to affirm the ASD diagnosis (including ruling out physical limitations [e.g., hearing, neurological conditions, or seizure disorder]);
    v. Educate and refer the family to appropriate assessing entities to determine the member's functional eligibility for enrollment in the HCBS Autism Waiver;
    vi. Follow-up with the HCBS Autism Waiver referral entity to ensure the entity has scheduled or completed the functional assessment;
    vii. Identify the appropriate level of care coordination (level II or III) and assign an MCO care coordinator experienced with ASD;
    viii. Coordinate and communicate with the member, family, PCP, specialists and other providers involved in the care of the member to develop a plan of service (POS) that identifies and addresses the member's medical, behavioral, and SDOH needs, such as developmental delays, behaviors, need to evaluate for ASD and apply for HCBS Waiver services, provide linkages and referrals to community resources;
    ix. Ensure referrals to covered services, non-covered services, and community resources, and secure necessary authorizations to ensure timely access to services and providers;
    x. Continue to coordinate, share information, and communication with the member's PCP, specialists, and other providers involved in the care of the member; and
    xi. Monitor the member's progress and ensure the POS/PCSP is meeting the member and family's identified needs, and adjust the POS/PCSP as necessary?

Bidder Name	Question Number
CareSource	34

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder helps to find ABA provider for PCP on first phone call. • Bidder has experienced nurse with qualifications to help member (10+ years and BH training). • Bidder completed HRA, SDOH, and PRAPARE assessments. • Bidder's Autism Spectrum Disorder (ASD) program graphic was informative. • Bidder referred to EPSDT program for well child checks. • Bidder provided an informative care journey table. • Bidder provided information regarding GuidingCare platform. • Bidder facilitated access to CareGiver Connect app. • Bidder's "wellness journey" shows good recovery-based language. • Bidder mentioned two different ABA providers and provided information on both and gave family the choice to choose between the two. • Bidder provided Attend Behavior e-learning platform targeting autism spectrum training. • Bidder utilized MyLife framework to develop PCSP for child and parents. • Bidder connected with Early Head Start as an alternative to traditional daycare. • Bidder indicated ASD program team that includes an in-house doctor. • Bidder indicates level II stratification.	Weaknesses were identified that can be easily overcome. • Bidder could have provided more detail regarding referral and outcomes to OT, PT and ST therapy services. • Bidder did not provide detail regarding any rule out of hearing or neurological conditions. • Bidder could have given more detail informing parents of autism waiver services that were available. • Bidder mentions EPSDT but not how it can be used or accessed and what services could be provided to the member. • Bidder mentions helping family access a "KanCare waiver program" but does not specify autism waiver. • Bidder indicates member receives letter regarding proposed recipient list, but no discussion with family regarding what this would mean for member or family. • Bidder created a person-centered care plan, but in the plan, it states "her" not "my". • Bidder does not include SMART goals. • Bidder's discussion of autism waiver does not show understanding of the waiver's requirement for an autism diagnosis. Bidder does not indicate that an actual autism diagnosis was ever given. • Bidder could include more detail including AutismSpeaks.org and/or other autism related resources for parents. • Bidder does not connect family with local CDDO to discuss additional potential services.

- Bidder indicates MCO Mobile app for appointments and other tools within the app.

General Notes

Rating

3

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**36**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Lola is a black female KanCare Member who just turned sixty-five (65) years of age and enrolled in the bidder's dual eligible special needs plan (D-SNP). She lives by herself in Abilene. Lola has high blood pressure and kidney disease. She receives dialysis twice a week and requires Transportation to access care because she does not have a vehicle. Lola has a difficult time hearing, making it difficult for her to communicate on the phone, schedule appointments and Transportation, and understand treatment recommendations from her Providers. While Lola's Primary Care and dialysis Providers are in the bidder's D-SNP network, her Nephrologist is not. Describe the bidder's approach to meeting Lola's needs.

RFP References	
7.1: General Requirements	7.1.1: Administrative Responsibilities
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.12: Care Transitions and Diversion Activities 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.2: Network Development 7.5.3: Provider Network Adequacy Standards 7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care 7.5.5: Provider Network Access Standards 7.5.7: Long-Term Services and Supports Provider Network Standards 7.5.10: Non-Participating Providers
7.10: Member Services	7.10.5: Written Member Materials Requirements
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations
1. Does the response fully address all aspects of the question? 2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP? 3. Does the response align with KanCare's care coordination goals and objectives? 4. Does the response describe how the bidder will become aware of the physical health, behavioral health, and SDOH needs (e.g., transportation needs beyond NEMT, nutritional needs) of this member (e.g., health screen, health risk assessment, needs assessment)? 5. Does the response describe how the bidder will ensure the member's immediate needs are met? 6. Does the response describe how the bidder will identify and meet the member's cultural needs when communicating with and providing care coordination and services to the member? 7. Does the response describe the bidder's approach to identifying and addressing health disparities for this member? 8. Does the response describe how the bidder will effectively communicate with and coordinate the care of the member in light of her hearing impairments (e.g., provision of aids and/or services to provide member information that are responsive to the member's hearing impairment, written methods of communication to coordinate appointments, providing in person care coordination support through a CHW, offering recurring dialysis appointments and prescheduled transportation to those appointments)? 9. Does the response describe the bidder's approach to engaging the member to participate in care coordination and disease management programs available to the member through the MCO (e.g., hypertension management, kidney disease) to meet her health and wellness goals? 10. Does the response describe how the bidder will determine the appropriate level of care coordination? 11. Does the response describe how the bidder will ensure the assigned care coordinator has appropriate qualifications relative to the member's health needs? 12. Does the response describe how the bidder will develop a Plan of Service (POS) that identifies and addresses the member's assessed needs (e.g., medical [kidney disease, hypertension, hearing impairment], behavioral, and SDOH (e.g., transportation) in an integrated manner? 13. Does the response describe how the bidder will utilize and share Medicare claims data to support care coordination? 14. Does the response describe the bidder's processes to share information with and involve the PCP, dialysis provider, Nephrologist, and other providers in the development of the POS and ongoing care? 15. Does the response describe the bidder's strategy to address the member's non-participating Nephrologist to ensure ongoing access to services and continuity of care, such as i. Allowing the member to continue to receive covered services from her current, non-participating Nephrologist to maintain continuity of care? ii. Attempting to contract with the non-participating Nephrologist? iii. Offering the member the option to be referred to an in-network Nephrologist? 16. Does the response describe how the bidder will ensure the member has access to providers that meet time and distance standards to ensure appropriate access to services? 17. Does the response describe the bidder's process for ensuring referrals to covered services, non-covered services, and community resources, and securing necessary authorizations to ensure timely access to services and providers? 18. Does the response describe how the bidder will monitor the member's progress and ensure the POS continues to meet the member's needs, adjusting the POS as necessary?

Bidder Name	Question Number
CareSource	36

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is very good. • Bidder had staff members trained in person-centered thinking and motivational interviewing. • Bidder developed a person-centered care plan. • Bidder provided connection to DSNP expanded programs including gym membership, food allowance, home fitness kit, emergency response system. • Bidder connected member with caregiver supports, for example MyHealth MyStrength app. • Bidder provided easy to follow layout of person-centered care plan services and referral. • Bidder indicates MCO auto assigned care coordinator with credentials as a licensed clinician with geriatric and health training. • Bidder indicates in-person screening and assessment, including HRA. • Bidder indicates single case agreement with nephrologist. • Bidder indicated hearing screening via ENT specialist. • Bidder indicated connection with phone adaptive tech. • Bidder indicated that when they weren't able to connect by phone or by letter an in-person visit was scheduled with the aid of a CHW. • Bidder obtained a release of information for the niece of the member so they could engage her. • Bidder changed their approach at the in-home visit because member was demonstrating confusion.	Weaknesses were identified that can be easily overcome. • Bidder created a person-centered care plan, but in the plan, it states "her" not "my". • Bidder did not indicate SMART goals. • Bidder provided conflicting information regarding potential waiver referral. • Bidder did not indicate connection with member was culturally competent. • Bidder does not demonstrate a full understanding of Kansas ILOS. • Bidder did not address hypertension.

- Bidder explained coverage under DSNP versus previous Medicaid only benefits to member.
- Bidder indicated referral to GuidingCare platform.
- Bidder provided connection to local hospital program Senior Life Solutions.

General Notes

Rating

4

Bidder Name	Question Number	Topic Area	Evaluation Criteria
CareSource	**37**	**Case Scenarios**	**Method of Approach**

RFP Technical Question
Jason is a twenty-eight (28)-year-old, male, American Indian who is currently living with his family on the Potawatomi Indian Reservation, but intermittently moves off and on the Reservation. The bidder has just been notified of Jason's Enrollment in the bidder's MCO. Not only is Jason a new KanCare Member, he is also new to managed care. Jason moved home after he was evicted from his apartment in Topeka for non-payment of rent. He has been unable to maintain ongoing employment due to inconsistent attendance. Prior to Enrollment with the bidder, Jason was recently seen at a nearby non-participating Indian health care Provider (IHCP) where he was diagnosed with type 2 diabetes. Jason has a Hemoglobin A1C of 8.76 and has a history of binge drinking since age sixteen (16). He said he drinks when he is depressed and that his drinking and depression have created problems for his maintaining work and in his relationship with his family and friends. The nurse practitioner at the IHCP prescribed Metformin, recommended Jason consider participating in a special diabetes program offered through the Tribe, and provided Jason with a referral to a non-participating Provider for a behavioral health assessment and treatment. Jason has not followed up on either the recommendation or the referral. Describe how the bidder will identify the needs of this KanCare Member, the bidder's approach to meeting the needs of the Member, and how the bidder will coordinate the Member's care.

RFP References	
7.1: General Requirements	7.1.7: Cooperation with Other Agencies
7.4: Care Coordination	7.4.1: Care Coordination Program Overview 7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments 7.4.4: Plans of Service and Person-Centered Service Planning 7.4.5: Care Coordination Stratification Levels and Contact Schedules 7.4.6: Care Coordination Roles and Responsibilities 7.4.7: Qualifications for Care Coordinators 7.4.10: Requirements for Specified Populations 7.4.13: Social Determinants of Health 7.4.15: Electronic Care Management System
7.5: Provider Network	7.5.2: Network Development 7.5.3: Provider Network Adequacy Standards 7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care 7.5.5: Provider Network Access Standards

RFP References	
	7.5.8: Behavioral Health Provider Network Standards 7.5.10: Non-Participating Providers
7.15: Information Systems	7.15.1: Health Information Technology and Health Information Exchange
Appendix C: Services	2.0: Medical Services 3.0: SUD Services 4.0: Mental Health Services
Appendix L: Care Coordination Matrix	Entire Appendix

Response Considerations

1. Does the response fully address all aspects of the question?
2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?
3. Does the response align with KanCare's care coordination goals and objectives?
4. Does the response describe how the bidder will become aware of the physical health, behavioral health, and SDOH needs (e.g., safe housing, food security, transportation, employment support) of this newly enrolled member (e.g., health screen, health risk assessment, needs assessment)?
5. Does the response describe how the bidder will Identify and address barriers to the member's engagement in his care?
6. Does the response describe how the bidder will ensure the member's immediate needs are met?
7. Does the response describe how the bidder will ensure the provision of culturally and linguistically appropriate communication, care coordination, and services to the member?
8. Does the response describe the bidder's approach to identifying and addressing health disparities for this member?
9. Does the response describe the bidder's approach to engaging the member in care coordination and disease management for treatment of diabetes (e.g., referral to CCBHC, use of Community Health Representative to support outreach and engagement)?
10. Does the response describe the respective care coordination roles and responsibilities of the MCO and CCBHC to avoid care coordination gaps and duplication?
11. Does the response describe how the bidder will ensure the appropriate level of care coordination?
12. Does the response describe how the bidder will ensure the assigned care coordinator has appropriate qualifications relative to the member's health needs?
13. Does the response describe how the bidder will ensure the development of a care plan that identifies and addresses assessed needs (e.g., medical [diabetes], behavioral [drinking, depression, social isolation]), and SDOH (e.g., employment, independent housing) in an integrated manner?
14. Does the response describe the bidder's processes to share information with and ensure the involvement of the CCBHC, IHCP, and other providers serving the member in the development of the care plan and ongoing care?
15. Does the response describe how the bidder will support choice counseling, including:
    i. The member's option to receive care coordination from the CCBHC or MCO;
    ii. The member's option to continue to receive covered services from his non-participating IHCP;
    iii. The member's option to be referred to a nearby in-network IHCP;
    iv. The member's option to be referred to a nearby CCBHC for further assessment of SUD, depression, and treatment needs?
16. Does the response describe how the bidder will ensure the care plan is implemented, monitored, and adjusted as necessary to ensure the care plan is meeting the member's identified needs?

Bidder Name	Question Number
CareSource	37

EVALUATOR NOTES

Response Strengths

- Bidder indicated behavioral health tribal liaison.
- Bidder indicated Native American assigned care coordinator with experience in working with Kansas Native American Affairs.
- Bidder indicates collaboration between IHCP, MCO care coordinator, and Valeo Behavioral Health Center (VBHC).
- Bidder indicates member as a level III risk stratification.
- Bidder indicates VAB for traditional healer.
- Bidder indicates weekly follow along for member.
- Bidder indicates staff cultural training called Redhawk.
- Bidder indicates participation in culturally competent recovery program Wellbriety.
- Bidder indicates MCO Food Connect program for diabetic friendly diet and a Free From Market resource.
- Bidder provided health rewards and incentives for the use of diabetes management tools.
- Bidder ensured next day appointment for outpatient substance abuse and BH counseling.
- Bidder indicated a collaborative effort with Haskell Indian Nations University to establish culturally competent CHWs.
- Bidder provided referral to certified peer support recovery specialist.

Response Weaknesses

The response is minimally acceptable.

- Bidder did not indicate SMART goals.
- Bidder indicates final outcomes but not necessarily the steps of how they were achieved, examples include for housing and employment. Bidder needs to provide more detail on how they would help member to explore and find affordable housing.
- Bidder does not offer member choice on services e.g., behavioral health providers, housing support services providers, and SUD providers.
- Bidder did not follow KDHE policy for updating service plan when level of care change was needed.
- Bidder expected Valeo BH to do the HRA and not MCO staff.
- Bidder did not discuss transportation to and from appointments with member.
- Bidder did not indicate what going back to work would mean for member's health insurance coverage.
- Bidder did not do a referral to HUD for at risk of homelessness connection to federal entitlement housing, causing Jason to lose days of eligibility in the HUD housing system. Bidder did not give member informed housing choice.
- Bidder did not connect member to housing support services, budgeting and housing sustainability services after individual is housed.
- Bidder did not indicate contract requirement of a housing transition specialist.

General Notes

Rating

2