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Via Email and
FedEx Priority Overnight #: 275846462496

Kansas Department of Administration
Todd Herman, Director
Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612
Email: todd.herman@ks.gov

Re: Supplemental Bid Protest—KanCare Medicaid & CHIP Capitated Managed Care Request for Proposal No. EVT 0009267

Dear Mr. Herman:

I write to supplement the June 4, 2024, bid protest previously submitted by CareSource Kansas, LLC ("CareSource") in this matter, that challenged the Department's May 7, 2024, award of contracts to Community Care Health Plan of Kansas, Inc. dba Healthy Blue, Sunflower State Health Plan, Inc., and United Healthcare of the Midwest, Inc. The challenged awards were made under the Kansas Medicaid and CHIP Capitated Managed Care Program ("KanCare") pursuant to the State of Kansas Request for Proposals No. EVT0009267 ("RFP").

As noted in CareSource's June 4 protest, CareSource had submitted multiple KORA requests for documents but had not yet received a complete response. CareSource still has not received all of the requested documents, but the Department did produce some additional materials that further support CareSource's protest. CareSource therefore submits this supplement to highlight these additional points.[1]

I. Supplemental Information Supporting CareSource's Protest

Though the Department has only produced a limited volume of additional documents since CareSource's June 4 protest, the materials provided bolster CareSource's contentions that bias in favor of Healthy Blue permeated the procurement, and that the RFP was violated as applied to

[1] The Department has not indicated that its production of documents in response to CareSource's KORA requests is complete, nor when its production will be complete; accordingly, CareSource reserves the right to further supplement its protest if additional relevant materials are provided.

CareSource's evaluation. Specifically, the Department's production of an early draft version of the technical evaluation report has revealed new information that supports and strengthens the arguments previously made by CareSource, as detailed below.

a. The Procurement Negotiation Committee ("PNC") Violated the RFP When It Did Not Evaluate CareSource's Cost Proposal.

As noted in its initial protest, having identified CareSource among the bidders that should advance to Phase 3, the PNC was required under the terms of the RFP to consider CareSource's cost proposal fully and to schedule an individual meeting with CareSource to discuss it. The PNC failed to do so.

Following the filing of CareSource's initial protest, the Department made available an earlier draft of the March 27, 2024, technical evaluation report, dated March 15, 2024. In this draft, the PNC requested "the cost proposals from ***all bidders***" to be released. Technical Proposal Evaluation Report and Procurement Negotiating Committee's Request for Cost Proposals (March 15, 2024) ("March 15 Draft Report"), at Section IV (attached as Exhibit 1). The final version of the report, dated March 27, 2024, stated the PNC requested that the cost proposals for five specific bidders—Sunflower, UnitedHealthCare, Aetna, Healthy Blue, ***and CareSource Health Plan***—advance to Phase 3. *See* Technical Proposal Evaluation Report and Procurement Negotiating Committee's Request for Cost Proposals (March 27, 2024) ("March 27 Report"), at Section IV (attached as Exhibit 2). Thus, the PNC consciously considered which bidders' cost proposals to request, and the inclusion of CareSource in that list was not by mistake—the PNC plainly intended to consider CareSource's cost proposal at the close of Phase 2.

However, as explained in CareSource's June 4 protest, CareSource's cost proposal was never released, reviewed, or evaluated, contrary to the PNC's recommendation and the requirement under the RFP that it consider CareSource's cost proposal in Phase 3. CareSource passed the technical phase of the RFP and was selected to advance to Phase 3, as evidenced by the edits made to the March 15 Draft Report. CareSource's improper and premature removal from Phase 3 considerations, without any explanation, remains a violation of the express terms of the RFP and applicable Kansas procurement law.

b. CareSource Was Inexplicably and Improperly Scored Lower Than Aetna and Healthy Blue.

CareSource's initial protest identified the Provider Network scoring area as an anomaly, as this was the only subject area in which CareSource's scores failed to compare to those of Aetna and Healthy Blue. Although CareSource scored equal to or higher than Healthy Blue as to Integrated Whole Person Care and Quality and Assurance, and Case Scenarios, and higher than Aetna as to Member Experience and Case Scenarios, CareSource inexplicably came in last among all the bidders in the Provider Network category, earning only 34% of the available points.

The March 15 Draft Report identified, for the first time, the members of the evaluation committees responsible for scoring the bidders' responses to the Provider Network questions.[2]

Specifically, Mendy Jump, MCO Managing Supervisor for Kansas Medicaid Operations, served as an evaluator on "Team 3: Provider Network/Operations." Upon information and belief, Ms. Jump was previously an employee for Blue Cross Blue Shield of Kansas (the minority owner of Healthy Blue) for more than 17 years. Not coincidentally, Healthy Blue earned the highest score of all bidders in this topic area, despite substantial similarities between its responses and CareSource's (the lowest scoring bidder in this category).

Moreover, as noted in CareSource's June 4 Protest, the PNC improperly sent "Additional MCO Questions" to bidders after the technical scoring in Phase 2 was completed—a step not identified or allowed under the RFP. In those questions, CareSource, the only other nonincumbent to receive the Department's Additional MCO Questions, was asked to provide details on its current numbers and letters of intent by provider type for its network, while Healthy Blue was merely asked to describe its plan to have its network in place. *See* Exhibits 3 and 4. A review of CareSource's and Healthy Blue's proposal submissions for Provider Network (despite redactions) indicates that this discrepancy in their treatment was unwarranted, as the responses contained a similar level of detail. *See* Exhibits 5 and 6. In short, CareSource's response was subjected to greater scrutiny than Healthy Blue's, further evidencing prejudice in favor of Healthy Blue and against CareSource in the scoring.

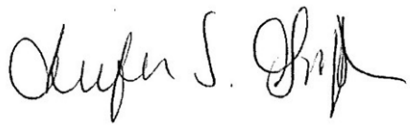
II. Conclusion and Relief Requested

The Department's subsequent production of records on its procurement website following CareSource's June 4, 2024, protest further established the State's failure to follow the requirements and procedures set forth in its RFP and Kansas procurement law. This failure led to a result that was erroneous, arbitrary, capricious, and contrary to the purposes of competitive bidding. For the reasons set forth above and in its June 4 submission, CareSource's protest should be sustained, and the relief requested in the June 4 protest should be granted.

[2] The names of the evaluators in each evaluation committee (or "team") were provided in a March 15, 2024, draft of the Technical Proposal Evaluation Report. *See* Exhibit 1. These names were deliberately omitted in the March 27, 2024, version made available to the public. *See* Exhibit 2.

Respectfully submitted,

LATHROP GPM LLP



Jennifer S. Griffin
Partner

Attachments: Exhibits 1 - 6

EXHIBIT
1

State of Kansas

KANCARE MEDICAID & CHIP CAPITATED MANAGED CARE

REQUEST FOR PROPOSAL (RFP)

RFP # EVT0009267

Technical Proposal Evaluation Report and Procurement Negotiating Committee's Request for Cost Proposals

March 15, 2024

Table of Contents

I. Background

On October 2, 2023, the State of Kansas (State) released a Request for Proposal (RFP), RFP number EVT0009267, to procure managed care organizations (MCOs) to provide statewide managed care for the Kansas Medicaid program and Children's Health Insurance Program (CHIP), collectively referred to as "KanCare".

The State intends to contract with three (3) MCOs to provide high quality, integrated, well-coordinated, and cost-effective services to improve the health outcomes of the populations currently covered by Medicaid and CHIP. Services included in the KanCare RFP are physical health services, behavioral health services, and long-term services and supports (LTSS), including nursing facility care and home- and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services and seven (7) Section 1915(c) HCBS waiver programs.

Through the KanCare RFP, the State is seeking to select MCOs that will improve upon an already recognized, innovative managed care program. The State recognizes that bidders will bring a variety of strengths, experiences, innovations, and added value to the KanCare program, all of which will be considered in the selection process. The State is interested in developing a vibrant business relationship with its MCOs to help identify, define, and implement a continuing series of market reforms that lead to optimal care quality and outcomes. These interests are reflected in the State's vision for KanCare — "Partnering together to support Medicaid members in achieving health, wellness, and independence for a healthier Kansas." To advance this vision, the State identified the following KanCare goals:

A. Improve member experience and satisfaction.

   1. Educate, engage, and empower members to personally define their health and wellness goals.

   2. Proactively solicit feedback from members and their families to improve the health care delivery system and member satisfaction.

B. Improve health outcomes by providing holistic care to members that is integrated, evidence-based, and well-coordinated, and that recognizes the impact of social determinants of health (SDOH).

   1. Provide integrated, whole-person health care, including physical health services, behavioral health services, LTSS, and promote independence and wellness.

   2. Utilize and expand the use of strategies that address the SDOH in Medicaid to further improve beneficiary health outcomes, reduce health disparities, and lower overall costs in Medicaid and CHIP.

   3. Expand the use of evidence-based practices and services shown to result in optimal health outcomes.

   4. Provide appropriate levels of person and family-centered care coordination to ensure timely access to necessary services, continuity of care, and effectiveness of services.

C. Reduce health care disparities.

1. Provide services in a manner that is responsive to the linguistic and cultural needs and preferences of members.
2. Ensure members with disabilities have equitable access to quality services.
3. Identify and remediate disparities in member health outcomes.

D. Expand provider network and direct care workforce capacity and skill sets.

1. Recruit and retain providers to ensure access to all provider types.
2. Improve member access to services in rural and frontier areas of the State of Kansas.
3. Increase the availability of telehealth and other technology to expand service access.
4. Expand the capacity and the skill sets of the direct care workforce.

E. Improve provider experience and encourage provider participation in Medicaid.

1. Reduce administrative burden for providers, including expanding standardization of certain provider requirements across KanCare MCOs.
2. Proactively solicit feedback from providers to understand provider challenges and barriers and collaborate to improve the health care delivery system.
3. Ensure timely and accurate payment to providers.
4. Expeditiously resolve provider concerns and issues.

F. Increase the use of cost-effective strategies to improve health outcomes and the service delivery system.

1. Encourage and incentivize member engagement in wellness and prevention services to adopt and maintain healthy behaviors and prevent more serious health care conditions.
2. Advance the strategic use of payment models, community reinvestments, and incentives to improve health outcomes, service delivery efficiency, member experience, and contain the cost of health care.

G. Leverage data to promote continuous quality improvement to achieve the goals of the KanCare program.

1. Consistently and frequently examine quantitative and qualitative data and information obtained through a variety of sources (e.g., members, providers, and other stakeholders) to evaluate the effectiveness of the strategies employed to achieve program goals, identify opportunities for improvement, and adjust the strategies to incorporate results and lessons learned.

Through the KanCare RFP, the State seeks to select MCOs that demonstrate and provide the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the State's vision and goals for KanCare. Contract awards will be based upon the best interests of the State.

The consulting firm Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, under contract with the Kansas Department of Health and Environment (KDHE), provided support to the State throughout the KanCare procurement, including in the evaluation process to facilitate and document the consensus evaluation process. Mercer's supportive role in the evaluation process did not include the evaluation of the bidders' proposals (i.e., including whether proposals met mandatory requirements, the review and rating/scoring of technical proposals, and the review and evaluation of cost proposals). Mercer did not review or have access to any of the bidders' proposals.

II. KanCare RFP Evaluation of Technical Proposals

Consistent with RFP Section 5, Evaluation Process, the State evaluated technical proposals using the following phased approach.

Phase 1 — Review of Mandatory Requirements

Proposals were received by the State on or before the RFP proposal submission deadline (2:00 pm CT, January 4, 2024) from the following seven (7) bidders:

- Aetna Better Health of Kansas, Inc. (also referred to herein as "Aetna")
- CareSource Kansas LLC (also referred to herein as "CareSource")
- Community Care Health Plan of Kansas, Inc. d/b/a Healthy Blue (also referred to herein as "Healthy Blue")
- Molina Healthcare of Kansas, Inc. (also referred to herein as "Molina")
- Sunflower State Health Plan, Inc. (also referred to herein as "Sunflower")
- UCare Kansas, Inc. (also referred to herein as "UCare")
- UnitedHealthCare of the Midwest, Inc. (also referred to herein as "UnitedHealthCare")

Proposals were reviewed by the State to ensure that mandatory requirements were met. No points were awarded for meeting mandatory requirements; mandatory requirements were evaluated on a pass/fail basis, meaning that failure to meet one or more of the mandatory requirements would eliminate a proposal from further consideration.

All seven (7) bidders met the mandatory requirements and all bidders' proposals were advanced to Phase 2, the review of technical proposals.

Phase 2 — Review of Technical Proposals

Evaluation Committees

The State established four (4) evaluation committees responsible for reviewing and evaluating bidders' responses to the KanCare RFP technical questions. Each evaluation committee was composed of five (5) individuals that collectively offered experience and expertise related to the subject matter covered in the RFP technical questions reviewed by that committee. The evaluation committees were comprised of staff from KDHE and the Kansas Department for Aging and Disability Services (KDADS) appointed by the State to evaluate and rate the bidders' responses to technical questions. All individuals involved in the evaluation process signed a Non-Disclosure — Conflict of Interest Agreement agreeing that they would ensure the confidentiality of the process and attesting that they had no real nor apparent conflict of interest regarding the RFP.

The four (4) evaluation committees (referred to as "teams" below) and evaluators were as follows:

Team 1: Care Coordination/Clinical

- Jolynn Foltz-McCall, KDHE
- Victor Nguyen, KDHE
- Biainett Smith, KDHE

- Charley Bartlett, KDADS-Behavioral Health Services (BHS)
- Seth Kilber, KDADS-LTSS

Team 2: Quality/Health Equity

- Christy Lane, KDHE
- John Powell, KDHE
- Anne Yeakley, KDHE
- Gary Henault, KDADS-BHS
- Jamie Katsbulas, KDADS-LTSS

Team 3: Provider Network/Operations

- Ryan Gonzalez, KDHE
- Mendy Jump, KDHE
- Suzy Moore, KDHE
- Patricia Satterlee, KDADS-BHS
- Matt Beery, KDADS-LTSS

Team 4: Case Scenarios

- Shalae Harris, KDHE
- Fran Seymour-Hunter, KDHE
- Laura Leistra, KDHE
- Melissa Bogart-Starkey, KDADS-BHS
- Paula Morgan, KDADS-LTSS

Evaluation Criteria

As specified in RFP Section 5.2.B, the evaluation of the response to each RFP technical question focused on one (1) or more of the following evaluation criteria:

- The bidder's method of approach
- The bidder's experience
- The bidder's capability

Rating Scale and Definitions

As referenced in RFP Section 5.2.C, the State established a rating scale ranging from one (1), the lowest, to five (5), the highest, to rate the response to each RFP technical question (see Attachment 1, KanCare RFP Rating Scale and Definitions). The KanCare RFP Rating Scale and Definitions was used to promote consistency within and between evaluation teams. As described below under Scoring Methodology, the consensus rating assigned to each response by the applicable evaluation team was used to calculate the total number of points earned for that response.

Scoring Methodology

Before publishing the RFP, the State developed a scoring methodology for bidders' responses to the RFP technical questions. The State determined the maximum number of points available for each technical question. The maximum available points and the consensus rating assigned to a particular question determined the points given for that response, as follows:

- Rating of 5 = 100% of available points for the question
- Rating of 4 = 75% of the available points for the question
- Rating of 3 = 50% of the available points for the question
- Rating of 2 = 25% of the available points for the question
- Rating of 1 = 0% of the available points for the question

For example, if the maximum number of potential points available for a technical question was 50 points and a bidder received a consensus rating of a four (4) for its response to the question, the bidder received 75% of 50 points, or 37.5 points for that technical question. If the bidder's response received a consensus rating of a three (3), the bidder received 50% of 50 points, or 25 points for that technical question.

A bidder's total score for its responses to RFP technical questions was the sum of the points given to each of the bidder's responses to questions. The maximum possible technical proposal score for this RFP was 1,000 points.

The State established that the scores, strengths and weaknesses of the bidders' responses to RFP technical questions were to be considered by the PNC, but would not, in and of themselves, be determinative of the PNC's recommendations to advance proposals to Phase 3 – Review of Cost Proposals nor be determinative of the PNC's recommendation of KanCare MCOs selected for award. In accordance with RFP Section 6, as a negotiated procurement pursuant to K.S.A. 75-37,102, selection and award of KanCare MCOs must be based upon the best interests of the State of Kansas.

Evaluator Training

Mercer provided evaluator training to the evaluation committee members prior to their evaluations of the responses to RFP technical questions. The training was focused on preparing evaluation committee members to understand and conduct their roles and responsibilities during the evaluation process, including the use of evaluation tools available to evaluators to guide their evaluation.

Evaluation Process for RFP Technical Questions

The State used a consensus review process to evaluate and rate each bidder's responses to RFP technical questions.

Independent Review

In preparation for participating in the consensus evaluation sessions, members of the evaluation committees independently evaluated and preliminarily rated responses to RFP technical questions assigned to their evaluation committee.

Mercer, on behalf of the State, randomly assigned the order in which evaluators were to independently evaluate each bidder's responses to the RFP technical questions. From January 18, 2024 to February 12, 2024, each evaluator independently read, evaluated, and rated responses to their assigned technical questions in the order specified by Mercer. Each evaluator documented their evaluation (i.e., preliminary rating, strengths, weaknesses, and notes) of the response to each question in a working draft of the evaluation guide for the applicable bidder in

preparation for consensus evaluation sessions. All evaluators completed their independent review of all bidders' responses assigned to them prior to beginning the consensus review process.

Consensus Review

From February 12, 2024, to February 28, 2024, each evaluation committee participated in a consensus review facilitated by Mercer. The order of review of each bidder's responses to technical questions during consensus evaluation sessions was randomly assigned by Mercer on behalf of the State. During the consensus reviews, evaluators used their individual preliminary ratings and notes documented in their draft evaluation guides to discuss and evaluate responses. Prior to finalizing a consensus rating, all members of the respective evaluation committee agreed to the final rating and documentation. The result was one consensus rating per question, per bidder, and supporting notes, documented by Mercer in the Master KanCare RFP Consensus Review Evaluation Guides.

Use of Subject Matter Experts as Advisors

Subject matter experts (SMEs) were available to the evaluation committees during the consensus evaluation sessions to review responses to specific RFP technical questions, in part or in whole, and to provide feedback for the evaluation committee's consideration.

The evaluation committees were advised as part of the evaluator training about the availability of SMEs during the consensus evaluation sessions, that SMEs could be requested by asking the facilitator of the consensus evaluation session, and the limited role of SMEs (i.e., advisory only; the role of SMEs did not include rating or scoring responses). No SMEs were requested or used during the consensus evaluation sessions.

III. Technical Proposal Review Results

KanCare RFP Total Technical Scores

The maximum possible technical proposal score for this RFP was 1,000 points. The following table shows each bidder's total score for its responses to KanCare RFP technical questions in rank order by point total, starting with the highest total points/score.

Rank	Offeror Name	Score
1	Sunflower	729.25
2	UnitedHealthCare	683.25
3	Aetna	522.00
4	Healthy Blue	522.00
5	CareSource	504.50
6	Molina	397.50
7	UCare	308.75

KanCare RFP Technical Scores by Topic Areas

The following table shows each bidder's technical proposal scores by topic area. Cells shaded in green represent the bidder(s) with the highest points in each topic area; cells shaded in yellow represent the bidder(s) with the lowest points in each topic area.

Topic Area	Sunflower	United Health Care	Aetna	Healthy Blue	Care Source	Molina	UCare	Total Available Points
Experience and Qualifications	69.25	59.50	54.50	59.50	49.50	23.75	23.75	95.00
Member Experience	60.00	60.00	41.25	47.50	46.25	33.75	20.00	80.00
Integrated, Whole Person Care	107.50	118.75	93.75	73.75	73.75	80.00	60.00	160.00
Utilization Management and Services	93.75	76.25	68.75	77.50	65.00	52.50	30.00	120.00
Quality Assurance	75.00	75.00	75.00	51.25	57.50	60.00	36.25	120.00
Provider Network	98.75	90.00	80.00	102.50	48.75	56.25	77.50	145.00
Case Scenarios	225.00	203.75	108.75	110.00	163.75	91.25	61.25	280.00
Total Available Points								**1,000.00**

KanCare RFP Summary of Ratings of Responses

A summary of the consensus ratings of responses to thirty-six technical questions (technical question number 18 was not rated/scored) for each bidder is captured below. Cells shaded in green represent the number of responses rated higher than a 3; cells shaded in grey represent the number of responses rated a 3; and cells shaded in yellow represent the number of responses rated lower than a 3.

For reference, as defined in Attachment 1, KanCare RFP Rating Scale and Definitions, a rating of 3 was awarded when the consensus evaluation team identified that the response was good, meaning that the response fully or nearly fully addressed the technical question and associated RFP requirements and adequately demonstrated the method of approach, capabilities and/or experience, as applicable to the question.

Bidder	Number of Responses by Consensus Rating				
	5	4	3	2	1
Sunflower	7	18	11	0	0
UnitedHealthCare	4	20	11	1	0
Aetna	0	12	15	8	1
Healthy Blue	0	11	18	7	0
CareSource	2	9	14	11	0
Molina	0	3	17	13	3
UCare	0	1	7	27	1

Summary of Technical Proposal Strengths and Weaknesses

A summary of technical proposal strengths and weaknesses for each bidder is captured below. Proposal strengths correspond to technical question responses that were rated above a 3 by the applicable consensus committee while weaknesses correspond to responses rated below a 3. The summaries of strengths and weaknesses are listed in the order of the RFP technical questions.

Sunflower State Health Plan, Inc.

Strengths

- Very good response regarding Medicaid managed care experience.
- Excellent response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Very good response regarding encouraging and engaging members to actively participate in their health care.
- Very good response regarding soliciting feedback from members/families and

using their feedback to improve member/family experience and the KanCare program.
- Very good response regarding improving the provider directory, including information included in the directory, the accuracy of the information, the usability of the online directory, and strategies to reduce provider burden associated with providing information.
- Very good response regarding the proposed MCO staffed care coordination model for KanCare.
- Very good response regarding screening, identifying, and using a closed-loop referral system to meet members' SDOH needs.
- Very good response regarding identifying and addressing health disparities.
- Very good response regarding ensuring appropriate utilization of services while reducing provider administrative burden.
- Very good response regarding ensuring compliance of the MCO's utilization management (UM) program with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Excellent response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Very good response regarding ensuring member access to non-emergency medical transportation.
- Very good response regarding providing and evaluating the effectiveness of the MCO's behavioral health crisis services.
- Very good response regarding the MCO's quality management program driving a program-wide culture of continuous quality improvement.
- Very good response regarding developing, managing, and monitoring an adequate, qualified provider network.
- Very good response regarding addressing workforce development challenges for home and community-based services (HCBS) and behavioral health services.
- Very good response regarding developing and implementing value-based purchasing arrangements.
- Excellent responses to address case scenarios involving the post-partum member, pregnant member with behavioral health needs, child with intellectual/developmental disability (IDD) and behavioral health needs, child member at risk for autism, and dual eligible member.
- Very good responses to address case scenarios involving the incarcerated member, child member in foster care, and hospital executive's concern about psychiatric boarding.

Weaknesses

- While minor weaknesses were identified in some responses, no responses were determined to be minimally acceptable or poor.

UnitedHealthCare of the Midwest, Inc.

Strengths

- Very good response regarding improving timely completion of member health screens.
- Very good response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Very good response regarding encouraging and engaging members to actively participate in their health care.
- Very good response regarding soliciting feedback from members/families and using their feedback to improve member/family experience and the KanCare program.
- Very good response regarding improving the provider directory, including information included in the directory, the accuracy of the information, the usability of the online directory, and strategies to reduce provider burden associated with providing information.
- Very good response regarding the proposed MCO staffed care coordination model for KanCare.
- Very good response regarding the use of community health workers (CHWs) and community health representatives (CHRs).
- Excellent response regarding advancing integrated, whole-person care.
- Very good response regarding screening, identifying, and using a closed-loop referral system to meet members' social determinants of health needs.
- Very good response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Very good response regarding providing and evaluating the effectiveness of the MCO's behavioral health crisis services.
- Very good response regarding increasing the provision of tobacco screening and cessation.
- Very good response regarding the MCO's quality management program driving a program-wide culture of continuous quality improvement.
- Very good response regarding ensuring timely access to quality dental care in all areas of the State.
- Very good response regarding encouraging provider network participation, improving provider experience, and reducing administrative burden.
- Very good response regarding developing and implementing value-based purchasing arrangements.
- Excellent responses to address case scenarios involving the child member at risk for autism, hospital executive's concern about psychiatric boarding, and American Indian member.
- Very good responses to address case scenarios involving the post-partum member, pregnant member with behavioral health needs, child member in foster care, member with IDD and behavioral health needs, and dual eligible member.

Weaknesses

- Minimally acceptable response to address case scenario involving the incarcerated member.

Aetna Better Health of Kansas, Inc.

Strengths

- Very good response regarding improving timely completion of member health screens.
- Very good response regarding encouraging and engaging members to actively participate in their health care.
- Very good response regarding advancing integrated, whole-person care.
- Very good response regarding screening, identifying, and using a closed-loop referral system to meet members' SDOH needs.
- Very good response regarding ensuring appropriate utilization of services while reducing provider administrative burden.
- Very good response regarding ensuring compliance of the MCO's UM program with MHPAEA.
- Very good response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Very good response regarding the MCO's quality management program driving a program-wide culture of continuous quality improvement.
- Very good response regarding encouraging provider network participation, improving provider experience, and reducing administrative burden.
- Very good response regarding developing and implementing value-based purchasing arrangements.
- Very good responses to address case scenarios involving the hospital executive's concern about psychiatric boarding and the American Indian member.

Weaknesses

- Minimally acceptable response regarding improving the provider directory, including information included in the directory, the accuracy of the information, the usability of the online directory, and strategies to reduce provider burden associated with providing information.
- Minimally acceptable response regarding ensuring member access to non-emergency medical transportation.
- Minimally acceptable response regarding ensuring timely access to quality dental care in all areas of the State.
- Minimally acceptable responses to address case scenarios involving the pregnant member, adult member on the IDD HCBS waiver, member with traumatic brain injury, child member in foster care, and child with IDD and behavioral health needs.
- Poor responses to address case scenario involving the incarcerated member.

Community Care Health Plan of Kansas, Inc. d/b/a Healthy Blue

Strengths

- Very good response regarding improving timely completion of member health screens.
- Very good response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Very good response regarding encouraging and engaging members to actively participate in their health care.
- Very good response regarding the use of CHWs and CHRs.
- Very good response regarding ensuring compliance of the MCO's UM program with MHPAEA.
- Very good response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Very good response regarding ensuring member access to non-emergency medical transportation.
- Very good response regarding developing, managing, and monitoring an adequate, qualified provider network.
- Very good response regarding ensuring timely access to quality dental care in all areas of the State.
- Very good response regarding encouraging provider network participation, improving experience, and reducing administrative burden.
- Very good response regarding developing and implementing value-based purchasing arrangements.

Weaknesses

- Minimally acceptable response regarding the proposed MCO staffed care coordination model for KanCare.
- Minimally acceptable response regarding identifying and addressing HCBS service gaps.
- Minimally acceptable responses to address case scenarios involving the incarcerated member, child member at risk for autism, hospital executive's concern about psychiatric boarding, dual eligible member, and American Indian member.

CareSource Kansas LLC

Strengths

- Very good response regarding improving timely completion of member health screens.
- Very good response regarding soliciting feedback from members/families and using their feedback to improve member/family experience and the KanCare program.

- Very good response regarding ensuring compliance of the MCO's UM program with MHPAEA.
- Very good response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Very good response regarding increasing the provision of tobacco screening and cessation.
- Very good response regarding improving performance on health care effectiveness data and information set (HEDIS) measures.
- Excellent responses to address case scenarios involving the post-partum member and pregnant member.
- Very good responses to address case scenarios involving the incarcerated member, child member in foster care, and dual eligible member.

Weaknesses

- Minimally acceptable response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Minimally acceptable response regarding advancing integrated, whole-person care.
- Minimally acceptable response regarding ensuring appropriate utilization of services while reducing provider administrative burden.
- Minimally acceptable response regarding ensuring member access to non-emergency medical transportation.
- Minimally acceptable response regarding identifying and addressing HCBS service gaps.
- Minimally acceptable response regarding developing, managing, and monitoring an adequate, qualified provider network.
- Minimally acceptable response regarding addressing workforce development challenges for HCBS and behavioral health services.
- Minimally acceptable response regarding ensuring timely access to quality dental care in all areas of the State.
- Minimally acceptable responses to address case scenarios involving the adult member on the IDD HCBS waiver, hospital executive's concern about psychiatric boarding, and American Indian member.

Molina Healthcare of Kansas, Inc.

Strengths

- Very good response regarding the use of CHWs and CHRs.
- Very good response regarding ensuring appropriate utilization of services while reducing provider administrative burden.
- Very good response regarding developing and implementing value-based purchasing arrangements.
- Very good responses to address case scenarios involving the post-partum member and pregnant member with behavioral health needs.

Weaknesses

- Minimally acceptable response regarding Medicaid managed care experience.
- Minimally acceptable response regarding improving timely completion of member health screens.
- Minimally acceptable response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Minimally acceptable response regarding soliciting feedback from members/families and using their feedback to improve member/family experience and the KanCare program.
- Minimally acceptable response regarding advancing integrated, whole-person care.
- Minimally acceptable response regarding ensuring member access to non-emergency medical transportation.
- Minimally acceptable response regarding providing and evaluating the effectiveness of the MCO's behavioral health crisis services.
- Minimally acceptable response regarding developing, managing, and monitoring an adequate, qualified provider network.
- Minimally acceptable response regarding addressing workforce development challenges for HCBS and behavioral health services.
- Minimally acceptable response regarding encouraging provider network participation, improving provider experience, and reducing administrative burden.
- Minimally acceptable responses to address case scenarios involving the incarcerated member, child with IDD and BH needs, and hospital executive's concern about psychiatric boarding.
- Poor responses to address case scenarios involving the adult member on the IDD HCBS waiver, member with traumatic brain injury, and dual eligible member.

UCare Kansas, Inc.

Strengths

- Very good response regarding encouraging provider network participation, improving provider experience, and reducing administrative burden.

Weaknesses

- Minimally acceptable response regarding Medicaid managed care experience.
- Minimally acceptable response regarding improving timely completion of member health screens.
- Minimally acceptable response regarding being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Minimally acceptable response regarding encouraging and engaging members to actively participate in their health care.
- Minimally acceptable response regarding soliciting feedback from

members/families and using their feedback to improve member/family experience and the KanCare program.
- Minimally acceptable response regarding improving the provider directory, including information included in the directory, the accuracy of the information, the usability of the online directory, and strategies to reduce provider burden associated with providing information.
- Minimally acceptable response regarding the use of CHWs and CHRs.
- Minimally acceptable response regarding advancing integrated, whole-person care.
- Minimally acceptable response regarding screening, identifying, and using a closed-loop referral system to meet members' SDOH needs.
- Minimally acceptable response regarding ensuring appropriate utilization of services while reducing provider administrative burden.
- Minimally acceptable response regarding ensuring compliance of the MCO's UM program with MHPAEA.
- Minimally acceptable response regarding collaborating with the State on pharmaceutical initiatives and best practices.
- Minimally acceptable response regarding ensuring member access to non-emergency medical transportation.
- Minimally acceptable response regarding providing and evaluating the effectiveness of the MCO's behavioral health crisis services.
- Minimally acceptable response regarding increasing the provision of tobacco screening and cessation.
- Minimally acceptable response regarding the MCO's quality management program driving a program-wide culture of continuous quality improvement.
- Minimally acceptable response regarding identifying and addressing HCBS service gaps.
- Poor response to the case scenarios involving the child with IDD and behavioral health needs, and minimally acceptable responses to all other case scenarios.

IV. PNC Request for Release of Cost Proposals

Consistent with RFP Section 5.2 F, as a result of the PNC's review of the information in the technical evaluation report, the PNC requests OPC to release the cost proposals from all bidders.

Attachment 1: KanCare RFP Rating Scale and Definitions

Rating Scale	Definition	Notes	% of Points
5	The response is excellent. The response fully addresses the technical question and associated RFP requirements and demonstrates superior method of approach, capabilities, and/or experience, as applicable to the question.	To support a five (5) rating, the evaluator must document that the response demonstrates: • A method of approach that is highly desirable to the State and represents best practice or innovation in many areas of the response. The description is detailed enough to determine that the approach is viable, geographically appropriate (when necessary) and describes how the Bidder will meet or exceed the requirements in the RFP; and/or • Highly desirable capabilities that are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, information technology (IT) systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet or exceed the requirements in the RFP; and/or • Extensive experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses.	100%
4	The response is very good. The response fully addresses the technical question and associated RFP requirements and demonstrates excellence in method of approach, capabilities and/or experience, as applicable to the question.	To support a four (4) rating, the evaluator must document that the response demonstrates: • A method of approach that is desirable to the State and represents best practice or innovation in some areas of the response. The description is detailed enough to determine that the approach is viable, geographically appropriate (when necessary) and describes how the Bidder will meet or exceed the requirements in the RFP; and/or	75%

Rating Scale	Definition	Notes	% of Points
		• Desirable capabilities that are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet or exceed the requirements in the RFP; and/or • Relevant experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses.	
3	The response is good. The response fully or nearly fully addresses the technical question and associated RFP requirements and adequately demonstrates the method of approach, capabilities and/or experience, as applicable to the questions.	To support a three (3) rating, the evaluator must document that the response demonstrates: • A method of approach that is desirable to the State and includes a description with enough detail to determine that the approach is viable and geographically appropriate (when necessary) and describes how the Bidder will meet the requirements in the RFP; and/or • Adequate capabilities are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • Some experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses but may have minor weaknesses that can be reasonably overcome.	50%

Rating Scale	Definition	Notes	% of Points
2	The response is minimally acceptable. The response does not fully address the technical question and/or associated RFP requirements, or does not sufficiently demonstrate the method of approach, capabilities, and/or experience, as applicable to the question.	To support a two (2) rating, the evaluator must document that the response demonstrates: • A method of approach that is not desirable to the State, lacks enough detail to determine that the approach is viable and geographically appropriate (when necessary), and/or does not describe how the Bidder will meet the requirements in the RFP; and/or • Some capabilities offered are insufficient, do not appear to be viable; or the response lacked sufficient detail to describe how the Bidder will develop the capabilities to meet the requirements of the RFP. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • Some, but limited, experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and/or • The response has a significant weakness or a number of weaknesses and/or a number of minor weaknesses that will be difficult to overcome.	25%

Rating Scale	Definition	Notes	% of Points
1	The response is poor or unacceptable. The response fails to address most elements of the technical question and/or associated RFP requirements, fails to demonstrate the method of approach, capabilities, and/or experience as applicable to the question, or no response was provided.	To support a one (1) rating, the evaluator must document that the response demonstrates: • A method of approach that lacks enough detail to evaluate how the Bidder will meet the requirements in the RFP and/or that violates the requirements in the RFP; and/or • Most or all capabilities offered are insufficient or do not appear to be viable and/or the response lacks enough detail to evaluate how the Bidder will develop the capabilities to meet the requirements in the RFP. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • A lack of relevant experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and/or • The response has significant weakness that cannot be overcome and/or a large number of minor weaknesses; and/or • The Bidder did not provide a response to the question.	0%

EXHIBIT
2

State of Kansas

KANCARE MEDICAID & CHIP CAPITATED MANAGED CARE

REQUEST FOR PROPOSAL (RFP)

RFP # EVT0009267

Technical Proposal Evaluation Report and Procurement Negotiating Committee's Request for Cost Proposals

March 27, 2024

Table of Contents

I. Background

On October 2, 2023, the State of Kansas (State) released a Request for Proposal (RFP), RFP number EVT0009267, to procure managed care organizations (MCOs) to provide statewide managed care for the Kansas Medicaid program and Children's Health Insurance Program (CHIP), collectively referred to as "KanCare".

The State intends to contract with three (3) MCOs to provide high quality, integrated, well-coordinated, and cost-effective services to improve the health outcomes of the populations currently covered by Medicaid and CHIP. Services included in the KanCare RFP are physical health services, behavioral health services, and long-term services and supports (LTSS), including nursing facility care and home- and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services and seven (7) Section 1915(c) HCBS waiver programs.

Through the KanCare RFP, the State is seeking to select MCOs that will improve upon an already recognized, innovative managed care program. The State recognizes that bidders will bring a variety of strengths, experiences, innovations, and added value to the KanCare program, all of which will be considered in the selection process. The State is interested in developing a vibrant business relationship with its MCOs to help identify, define, and implement a continuing series of market reforms that lead to optimal care quality and outcomes. These interests are reflected in the State's vision for KanCare — "Partnering together to support Medicaid members in achieving health, wellness, and independence for a healthier Kansas." To advance this vision, the State identified the following KanCare goals:

A. Improve member experience and satisfaction.

   1. Educate, engage, and empower members to personally define their health and wellness goals.

   2. Proactively solicit feedback from members and their families to improve the health care delivery system and member satisfaction.

B. Improve health outcomes by providing holistic care to members that is integrated, evidence-based, and well-coordinated, and that recognizes the impact of social determinants of health (SDOH).

   1. Provide integrated, whole-person health care, including physical health services, behavioral health services, LTSS, and promote independence and wellness.

   2. Utilize and expand the use of strategies that address the SDOH in Medicaid to further improve beneficiary health outcomes, reduce health disparities, and lower overall costs in Medicaid and CHIP.

   3. Expand the use of evidence-based practices and services shown to result in optimal health outcomes.

   4. Provide appropriate levels of person and family-centered care coordination to ensure timely access to necessary services, continuity of care, and effectiveness of services.

C. Reduce health care disparities.

1. Provide services in a manner that is responsive to the linguistic and cultural needs and preferences of members.
2. Ensure members with disabilities have equitable access to quality services.
3. Identify and remediate disparities in member health outcomes.

D. Expand provider network and direct care workforce capacity and skill sets.

1. Recruit and retain providers to ensure access to all provider types.
2. Improve member access to services in rural and frontier areas of the State of Kansas.
3. Increase the availability of telehealth and other technology to expand service access.
4. Expand the capacity and the skill sets of the direct care workforce.

E. Improve provider experience and encourage provider participation in Medicaid.

1. Reduce administrative burden for providers, including expanding standardization of certain provider requirements across KanCare MCOs.
2. Proactively solicit feedback from providers to understand provider challenges and barriers and collaborate to improve the health care delivery system.
3. Ensure timely and accurate payment to providers.
4. Expeditiously resolve provider concerns and issues.

F. Increase the use of cost-effective strategies to improve health outcomes and the service delivery system.

1. Encourage and incentivize member engagement in wellness and prevention services to adopt and maintain healthy behaviors and prevent more serious health care conditions.
2. Advance the strategic use of payment models, community reinvestments, and incentives to improve health outcomes, service delivery efficiency, member experience, and contain the cost of health care.

G. Leverage data to promote continuous quality improvement to achieve the goals of the KanCare program.

1. Consistently and frequently examine quantitative and qualitative data and information obtained through a variety of sources (e.g., members, providers, and other stakeholders) to evaluate the effectiveness of the strategies employed to achieve program goals, identify opportunities for improvement, and adjust the strategies to incorporate results and lessons learned.

Through the KanCare RFP, the State seeks to select MCOs that demonstrate and provide the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the State's vision and goals for KanCare. Contract awards will be based upon the best interests of the State.

The consulting firm Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, under contract with the Kansas Department of Health and Environment (KDHE), provided support to the State throughout the KanCare procurement, including in the evaluation process to facilitate and document the consensus evaluation process. Mercer's supportive role in the evaluation process did not include the evaluation of the bidders' proposals (i.e., including whether proposals met mandatory requirements, the review and rating/scoring of technical proposals, and the review and evaluation of cost proposals). Mercer did not review or have access to any of the bidders' proposals.

II. KanCare RFP Evaluation of Technical Proposals

Consistent with RFP Section 5, Evaluation Process, the State evaluated technical proposals using the following phased approach.

Phase 1 — Review of Mandatory Requirements

Proposals were received by the State on or before the RFP proposal submission deadline (2:00 pm CT, January 4, 2024) from the following seven (7) bidders:

- Aetna Better Health of Kansas, Inc. (also referred to herein as "Aetna")
- CareSource Kansas LLC (also referred to herein as "CareSource")
- Community Care Health Plan of Kansas, Inc. d/b/a Healthy Blue (also referred to herein as "Healthy Blue")
- Molina Healthcare of Kansas, Inc. (also referred to herein as "Molina")
- Sunflower State Health Plan, Inc. (also referred to herein as "Sunflower")
- UCare Kansas, Inc. (also referred to herein as "UCare")
- UnitedHealthCare of the Midwest, Inc. (also referred to herein as "UnitedHealthCare")

Proposals were reviewed by the State to ensure that mandatory requirements were met. No points were awarded for meeting mandatory requirements; mandatory requirements were evaluated on a pass/fail basis, meaning that failure to meet one or more of the mandatory requirements would eliminate a proposal from further consideration.

All seven (7) bidders met the mandatory requirements and all bidders' proposals were advanced to Phase 2, the review of technical proposals.

Phase 2 — Review of Technical Proposals

Evaluation Committees

The State established four (4) evaluation committees responsible for reviewing and evaluating bidders' responses to the KanCare RFP technical questions. Each evaluation committee was composed of five (5) individuals that collectively offered experience and expertise related to the subject matter covered in the RFP technical questions reviewed by that committee. The evaluation committees were comprised of staff from KDHE and the Kansas Department for Aging and Disability Services (KDADS) appointed by the State to evaluate and rate the bidders' responses to technical questions. All individuals involved in the evaluation process signed a Non-Disclosure — Conflict of Interest Agreement agreeing that they would ensure the confidentiality of the process and attesting that they had no real nor apparent conflict of interest regarding the RFP.

The four (4) evaluation committees (referred to as "teams" below) were as follows:

- Team 1: Care Coordination/Clinical
- Team 2: Quality/Health Equity
- Team 3: Provider Network/Operations
- Team 4: Case Scenarios

Evaluation Criteria

As specified in RFP Section 5.2.B, the evaluation of the response to each RFP technical question focused on one (1) or more of the following evaluation criteria:

- The bidder's method of approach
- The bidder's experience
- The bidder's capability

Rating Scale and Definitions

As referenced in RFP Section 5.2.C, the State established a rating scale ranging from one (1), the lowest, to five (5), the highest, to rate the response to each RFP technical question (see Attachment 1, KanCare RFP Rating Scale and Definitions). The KanCare RFP Rating Scale and Definitions was used to promote consistency within and between evaluation teams. As described below under Scoring Methodology, the consensus rating assigned to each response by the applicable evaluation team was used to calculate the total number of points earned for that response.

Scoring Methodology

Before publishing the RFP, the State developed a scoring methodology for bidders' responses to the RFP technical questions. The State determined the maximum number of points available for each technical question. The maximum available points and the consensus rating assigned to a particular question determined the points given for that response, as follows:

- Rating of 5 = 100% of available points for the question
- Rating of 4 = 75% of the available points for the question
- Rating of 3 = 50% of the available points for the question
- Rating of 2 = 25% of the available points for the question
- Rating of 1 = 0% of the available points for the question

For example, if the maximum number of potential points available for a technical question was 50 points and a bidder received a consensus rating of a four (4) for its response to the question, the bidder received 75% of 50 points, or 37.5 points for that technical question. If the bidder's response received a consensus rating of a three (3), the bidder received 50% of 50 points, or 25 points for that technical question.

A bidder's total score for its responses to RFP technical questions was the sum of the points given to each of the bidder's responses to questions. The maximum possible technical proposal score for this RFP was 1,000 points.

The State established that the scores, strengths and weaknesses of the bidders' responses to RFP technical questions were to be considered by the PNC, but would not, in and of themselves, be

determinative of the PNC's recommendations to advance proposals to Phase 3 – Review of Cost Proposals nor be determinative of the PNC's recommendation of KanCare MCOs selected for award. In accordance with RFP Section 6, as a negotiated procurement pursuant to K.S.A. 75-37,102, selection and award of KanCare MCOs must be based upon the best interests of the State of Kansas.

Evaluator Training

Mercer provided evaluator training to the evaluation committee members prior to their evaluations of the responses to RFP technical questions. The training was focused on preparing evaluation committee members to understand and conduct their roles and responsibilities during the evaluation process, including the use of evaluation tools available to evaluators to guide their evaluation.

Evaluation Process for RFP Technical Questions

The State used a consensus review process to evaluate and rate each bidder's responses to RFP technical questions.

Independent Review

In preparation for participating in the consensus evaluation sessions, members of the evaluation committees independently evaluated and preliminarily rated responses to RFP technical questions assigned to their evaluation committee.

Mercer, on behalf of the State, randomly assigned the order in which evaluators were to independently evaluate each bidder's responses to the RFP technical questions. From January 18, 2024, to February 12, 2024, each evaluator independently read, evaluated, and rated responses to their assigned technical questions in the order specified by Mercer. Each evaluator documented their evaluation (i.e., preliminary rating, strengths, weaknesses, and notes) of the response to each question in a working draft of the evaluation guide for the applicable bidder in preparation for consensus evaluation sessions. All evaluators completed their independent review of all bidders' responses assigned to them prior to beginning the consensus review process.

Consensus Review

From February 12, 2024, to February 28, 2024, each evaluation committee participated in a consensus review facilitated by Mercer. The order of review of each bidder's responses to technical questions during consensus evaluation sessions was randomly assigned by Mercer on behalf of the State. During the consensus reviews, evaluators used their individual preliminary ratings and notes documented in their draft evaluation guides to discuss and evaluate responses. Prior to finalizing a consensus rating, all members of the respective evaluation committee agreed to the final rating and documentation. The result was one consensus rating per question, per bidder, and supporting notes, documented by Mercer in the Master KanCare RFP Consensus Review Evaluation Guides.

Use of Subject Matter Experts as Advisors

Subject matter experts (SMEs) were available to the evaluation committees during the consensus evaluation sessions to review responses to specific RFP technical questions, in part or in whole, and to provide feedback for the evaluation committee's consideration.

The evaluation committees were advised as part of the evaluator training about the availability of SMEs during the consensus evaluation sessions, that SMEs could be requested by asking the facilitator of the consensus evaluation session, and the limited role of SMEs (i.e., advisory only; the role of SMEs did not include rating or scoring responses). No SMEs were requested or used during the consensus evaluation sessions.

III. Technical Proposal Review Results

KanCare RFP Total Technical Scores

The maximum possible technical proposal score for this RFP was 1,000 points. The following table shows each bidder's total score for its responses to KanCare RFP technical questions in rank order by point total, starting with the highest total points/score.

Rank	Offeror Name	Score
1	Sunflower	729.25
2	UnitedHealthCare	683.25
3	Aetna	522.00
4	Healthy Blue	522.00
5	CareSource	504.50
6	Molina	397.50
7	UCare	308.75

KanCare RFP Technical Scores by Topic Areas

The following table shows each bidder's technical proposal scores by topic area. Cells shaded in green represent the bidder(s) with the highest points in each topic area; cells shaded in yellow represent the bidder(s) with the lowest points in each topic area.

Topic Area	Sunflower	United Health Care	Aetna	Healthy Blue	Care Source	Molina	UCare	Total Available Points
Experience and Qualifications	69.25	59.50	54.50	59.50	49.50	23.75	23.75	95.00
Member Experience	60.00	60.00	41.25	47.50	46.25	33.75	20.00	80.00
Integrated, Whole Person Care	107.50	118.75	93.75	73.75	73.75	80.00	60.00	160.00
Utilization Management and Services	93.75	76.25	68.75	77.50	65.00	52.50	30.00	120.00
Quality Assurance	75.00	75.00	75.00	51.25	57.50	60.00	36.25	120.00
Provider Network	98.75	90.00	80.00	102.50	48.75	56.25	77.50	145.00
Case Scenarios	225.00	203.75	108.75	110.00	163.75	91.25	61.25	280.00
Total Available Points								**1,000.00**

KanCare RFP Summary of Ratings of Responses

A summary of the consensus ratings of responses to thirty-six technical questions (technical question number 18 was not rated/scored) for each bidder is captured below. Cells shaded in green represent the number of responses rated higher than a 3; cells shaded in grey represent the number of responses rated a 3; and cells shaded in yellow represent the number of responses rated lower than a 3.

For reference, as defined in Attachment 1, KanCare RFP Rating Scale and Definitions, a rating of 3 was awarded when the consensus evaluation team identified that the response was good, meaning that the response fully or nearly fully addressed the technical question and associated RFP requirements and adequately demonstrated the method of approach, capabilities and/or experience, as applicable to the question.

Bidder	Number of Responses by Consensus Rating				
	5	4	3	2	1
Sunflower	7	18	11	0	0
UnitedHealthCare	4	20	11	1	0
Aetna	0	12	15	8	1
Healthy Blue	0	11	18	7	0
CareSource	2	9	14	11	0
Molina	0	3	17	13	3
UCare	0	1	7	27	1

Examples of Technical Proposal Strengths and Weaknesses

Examples of technical proposal strengths and weaknesses, described in more detail in the Master KanCare RFP Consensus Review Evaluation Guides for each bidder, are captured below. Examples of proposal strengths correspond to technical question responses that were rated above a 3 by the applicable consensus committee while examples of weaknesses correspond to responses rated below a 3. The examples of strengths and weaknesses are listed in the order of the RFP technical questions.

Sunflower State Health Plan, Inc.

Strengths

- Relevant Medicaid managed care experience in multiple states.
- Strategies for being an effective partner to the State and other stakeholders, including providers and other MCOs, to achieve the State's vision and goals.
- Approach to encouraging and engaging members to actively participate in their health care, including examples of interventions and related improved outcomes.

- Multiple strategies to soliciting feedback from members/families and using that feedback to improve member/family experience and the KanCare program.
- Strategies for improving the provider directory, including information included in the directory beyond the required fields, stakeholder-informed processes for maintaining the accuracy of the information, enhancing the usability of the online directory through several features, and strategies to reduce provider burden associated with providing information.
- MCO staffed care coordination model approach and capabilities, including statewide staff distribution to meet member needs and providing actionable data and information to care coordinators.
- Multiple approaches to screening, identifying, and using a closed-loop referral system to meet members' SDOH needs.
- Strategies for identifying and addressing health disparities that included a strategy for using data and an understanding of the limitations of the data.
- Approaches to ensuring appropriate utilization of services while reducing provider administrative burden.
- Strategies for ensuring compliance of the MCO's utilization management (UM) program with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Multiple examples of how the MCO has and will participate and collaborate with the State on pharmaceutical initiatives and best practices, including clinical initiatives, sharing data with the State to inform policy making, and programs to reduce the administrative burden for providers.
- Multiple strategies for ensuring member access to non-emergency medical transportation (NEMT), including use of the member advisory committee and member focus groups to determine a vendor and examples of active vendor oversight.
- Strategies for providing and evaluating the effectiveness of the MCO's behavioral health crisis services, including partnering with stakeholders, use of grant funding to promote access to crisis services, and use of predictive modeling.
- MCO's quality management program approach to drive a program-wide culture of continuous quality improvement, including a focus on quality in rural and frontier areas, LTSS, and behavioral health.
- Multiple strategies for developing, managing, and monitoring an adequate, qualified provider network, including a provider incentive program, multiple telemedicine methods, and mobile service delivery.
- Multiple strategies and partnerships for addressing workforce development challenges for home and community-based services (HCBS) and behavioral health services, including financial incentives and career growth opportunities for direct care workers, telehealth options, and MCO commitments to the certified community behavioral health clinic (CCBHC) model.
- Experience and approach to developing and implementing multiple value-based purchasing (VBP) arrangements, including a well-defined list of priority areas and examples of performance outcomes.
- Approach to identifying, addressing, and coordinating member/family care needs for the case scenarios involving the postpartum member, pregnant

member with behavioral health needs, incarcerated member, child member in foster care, child member with intellectual/developmental disability (IDD) and behavioral health needs, child member at risk for autism, and dual eligible member.
- Approaches to address the hospital executive's concern about psychiatric boarding, including the use of care coordination, stakeholder partnerships to develop strategies, and use of data and analytics.

Weaknesses

- While minor weaknesses were identified in some responses, no responses were determined to be minimally acceptable or poor.

UnitedHealthCare of the Midwest, Inc.

Strengths

- Innovative approaches and examples of initiatives resulting in measurable improvements in completing member health screens.
- Strategies for being an effective partner with the State and other stakeholders, including providers and other MCOs, and experience relevant to effectively partnering to achieve identified program goals.
- Relevant experience and approaches to encouraging and engaging members to actively participate in their health care, including the use of incentives and health portal/health applications.
- Approach to soliciting feedback from members/families, including multiple avenues for member engagement to provide feedback and using feedback to improve member/family experience and the KanCare program.
- Strategies for improving the provider directory, including providing information in the directory beyond required fields, multiple processes for maintaining the accuracy of the information, enhancing the usability of the online directory through different features, and using strategies to reduce provider burden associated with providing information.
- Strategies and capabilities that support the proposed MCO staffed care coordination model for KanCare, including care coordination staffing, systems, and member engagement methods.
- Use of community health workers (CHWs) and community health representatives (CHRs), including current and planned staffing, measuring and monitoring activities, and a commitment to support CHWs.
- Multiple strategies for advancing integrated, whole-person care, including the use of training, data analytics, and tools.
- Capabilities and strategies related to screening, identifying, and using a closed-loop referral system to meet members' social determinants of health (SDOH) needs, including the use of information systems, training, and a variety of tools.
- Approach to collaborating with the State on pharmaceutical initiatives and best practices, including multiple tools and examples of relevant experience.

- Strategies for providing and evaluating the effectiveness of the MCO's behavioral health crisis services, including partnering with schools, development of behavioral health programs, and use of technology/platform designed to reduce emergency department (ED) visits.
- Strategies, particularly those used at initial stage of member engagement, to increase the provision of tobacco screening and cessation.
- MCO's quality management program approach to driving a program-wide culture of continuous quality improvement, including the use of data, tools, and committee structures.
- Multiple strategies for ensuring timely access to quality dental care in all areas of the State.
- Multiple strategies for encouraging provider network participation, improving provider experience, and reducing administrative burden.
- Strategies and experience relevant to developing and implementing multiple types of VBP and alternative payment model (APM) arrangements to achieve program goals, such as reducing unnecessary ED utilization and hospital readmissions.
- Approach to identifying, addressing, and coordinating member/family care needs to address the case scenarios involving the postpartum member, pregnant member with behavioral health needs, child member in foster care, member with IDD and behavioral health needs, child member at risk for autism, dual eligible member, and American Indian member.
- Strategies, including root cause analysis and employing a collaborative approach with stakeholders, to understand and effectively address hospital executive's concern about psychiatric boarding in the ED.

Weaknesses

- Approach to identifying, addressing, and coordinating the member's needs in the case scenario involving the incarcerated member, including failing to provide adequate person-centered planning and timely care coordination following the member's release from incarceration.

Aetna Better Health of Kansas, Inc.

Strengths

- Multiple strategies and new initiatives for improving the timely completion of member health screens.
- Approach to encouraging and engaging members to actively participate in their health care, including the use of a variety of member communication channels and strategies and providing members with rewards for engagement.
- Approach to advancing integrated, whole-person care, including provider incentives like VBP and embedding providers in key service locations.
- Multiple strategies for screening, identifying, and meeting members' SDOH needs, including hiring individuals with lived experience, relationships with

community benefit organizations, and a closed-loop referral system.
- Approach to ensuring appropriate utilization of services while reducing provider administrative burden, including minimizing a number of prior authorization requirements, data analysis and reporting, and methods for driving desirable member actions.
- Approach to ensuring compliance of the MCO's UM program with MHPAEA, including analyzing benefit changes, regular parity committee meetings, and using evidence-based medical necessity criteria.
- Experience with and approach to collaborating with the State on pharmaceutical initiatives and best practices, including moving toward a single pharmacy benefits manager (PBM), partnering with the independent pharmacy enhanced services network, and installing health screen kiosks in pharmacies.
- Quality management program approach and capabilities to drive a program-wide culture of continuous quality improvement.
- Multiple strategies for encouraging provider network participation, improving provider experience, and reducing administrative burden.
- Approach to developing and implementing VBP arrangements, including multiple examples targeted at different types of providers.
- Approach to addressing the hospital executive's call to provider services about psychiatric boarding concerns, including the use of community partnerships and collaboration for short-term and long-term solutions.
- Approach to identifying, addressing, and coordinating the needs of and offering choices to the member in the case scenario involving the American Indian member in a culturally appropriate manner.

Weaknesses

- Did not adequately describe how the MCO would improve the provider directory, including limited information on the strategies and timeline for improving the accuracy of the information and the usability of the online directory and on strategies to reduce provider burden associated with providing information.
- Did not fully describe strategies for ensuring member access to NEMT.
- Did not fully describe strategies for ensuring timely access to quality dental care in all areas of the State.
- Did not provide sufficient detail to determine whether the presenting needs of the member/family were fully identified and addressed in the case scenarios involving the pregnant member, adult member on the IDD HCBS waiver, member with traumatic brain injury (TBI), child member in foster care, and child member with IDD and behavioral health needs.
- Did not provide sufficient detail to determine whether the needs of the member were fully identified and addressed in the case scenario involving the incarcerated member, and in some areas reflected an approach that is not consistent with RFP requirements/expectations.

Community Care Health Plan of Kansas, Inc. d/b/a Healthy Blue

Strengths

- Approach to improving timely completion of member health screens, including examples of strong member engagement techniques, mobile screening van for rural areas, and use of data mining to locate members.
- Detailed strategies and examples demonstrating the MCO's approach to becoming an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Wide variety of member-focused services, such as communication channels and use of data, to encourage and engage members to actively participate in their health care.
- Detailed strategy for using CHWs and CHRs, including the MCO's CHW/CHR training plan, engagement strategy, and approach to member education.
- Approach to ensuring compliance of the MCO's UM program with MHPAEA, including continuous monitoring and providing a detailed plan on the use of a parity governance committee.
- Multiple strategies and experience related to collaborating with the State on pharmaceutical initiatives and best practices, including reducing opioid use, detailed monitoring plans, and leveraging work in other markets.
- Comprehensive strategies to ensure member access to NEMT, including technology to assist members with transportation needs, driver incentives for performance, and enhanced reimbursement for NEMT driver coverage in rural and frontier areas.
- Strategies for developing, managing, and monitoring an adequate, qualified provider network, including the use of mobile clinics in rural and frontier areas, telehealth approaches, and data sources to monitor the network.
- Multiple strategies to ensure timely access to quality dental care in all areas of the State, including rural and frontier areas.
- A number of innovative strategies to encourage provider network participation, improve experience, and reduce administrative burden, including dashboards, incentives, and outreach efforts.
- Experience and approach to developing and implementing multiple VBP arrangements, including detailed approaches for priority areas that support KanCare goals.

Weaknesses

- Did not provide adequate detail in several parts of the response related to the MCO staffed care coordination model for KanCare, including descriptions of care coordination roles and responsibilities.
- Did not adequately describe the MCO's approach to addressing service gaps, particularly in rural and frontier areas of the State.
- Lacked detail and did not fully address identifying, coordinating, and addressing

member/family needs in response to the case scenarios involving the incarcerated member, child member at risk for autism, dual eligible member, and American Indian member.
- Lacked detail and did not provide actionable solutions to address the hospital executive's concern about psychiatric boarding in the case scenario.

CareSource Kansas LLC

Strengths

- Approach to improving timely completion of member health screens, including member incentives, innovative communication platforms, and strategies to address health disparities.
- Approach to soliciting feedback from members/families and using feedback to improve member/family experience and the KanCare program, including establishment of diverse committees, surveys, and use of data.
- Approach to ensuring compliance of the MCO's UM program with MHPAEA, including training, audits, and policies and procedures.
- Approach to collaborating with the State on pharmaceutical initiatives and best practices, including collaborative initiatives, use of an advisory board, and use of a third-party auditor to monitor the MCO's PBM.
- Approach to increasing the provision of tobacco screening and cessation, including tobacco screening for youth, member/provider incentives, and inclusion of all forms of tobacco in screening efforts.
- Approach to improving performance on health care effectiveness data and information set (HEDIS) measures, including specific approaches for each HEDIS metric in the question, multiple member engagement techniques, and collaboration strategies.
- Approach to identifying, coordinating, and addressing member/family needs in response to the case scenarios involving the postpartum member, pregnant member, incarcerated member, child member in foster care, and dual eligible member.

Weaknesses

- Very limited information and details regarding the MCO's approach to being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Limited information, detail, and examples of the MCO's approach to advancing integrated, whole -person care.
- Did not fully describe and explain how the MCO would ensure appropriate utilization of services while reducing provider administrative burden.
- Lacked detail on how the MCO would meet NEMT access and service delivery standards.
- Did not provide sufficient detail to demonstrate how the MCO would identify and address HCBS service gaps.

- Did not demonstrate a comprehensive understanding of Kansas-specific network gaps, did not clarify that using telehealth would not be appropriate for all populations, and did not provide sufficient information regarding the timeline for provider recruiting and contracting.
- Lacked detail and did not provide detailed solutions for HCBS and behavioral health workforce issues in rural and frontier areas.
- Did not demonstrate a comprehensive understanding of Kansas-specific network gaps and provided limited details on how the MCO would close identified dental network gaps to ensure timely access to quality dental care.
- Lacked detail and did not fully address identifying, coordinating, and addressing member/family needs in response to the case scenarios involving the adult member on the IDD HCBS waiver and the American Indian member.
- Lacked detail and did not sufficiently address the case scenario involving the hospital executive's concern about psychiatric boarding.

Molina Healthcare of Kansas, Inc.

Strengths

- Strategies for expanding the use of CHWs and CHRs, including outreach to members, incentives to integrate CHWs in provider offices, and moving CHW training into a college credit program.
- Multiple strategies for ensuring appropriate utilization of services while reducing provider administrative burden, including incorporating providers in the MCO's UM committee and offering a strong provider portal.
- Experience with and approach to developing and implementing VBP arrangements, including strategies for assessing providers for readiness to participate in such arrangements.
- Approach to identifying, coordinating, and addressing member/family needs in response to the case scenarios involving the postpartum member and pregnant member.

Weaknesses

- Limited experience providing services similar to KanCare; only a few plans referenced in the response offer all services that are available in KanCare. Multiple instances of noncompliance and protected health information (PHI) breaches, some resulting in large fines, with minimal information provided about the corrective action taken.
- Limited response and detail about the MCO's approach to improving timely completion of member health screens.
- Limited response and detail describing the MCO's approach to being an effective partner with the State and other stakeholders to achieve the State's vision and goals.
- Lacked sufficient detail about the MCO's approach to soliciting feedback from members/families and using feedback to improve member/family experience

and the KanCare program.
- Did not sufficiently describe approaches to advancing integrated, whole-person care, including a lack of information about how the MCO will evaluate and monitor integration strategies.
- Did not address rural and frontier NEMT service access strategies and lacked detail regarding member ability to access NEMT services.
- Lacked detail regarding the method of approach to evaluating the effectiveness of the MCO's behavioral health crisis services, ensuring comprehensive member access to services, and describing the MCO's role in stakeholder partnerships.
- Lacked information about the MCO's approach to network development, including a lack of detail on provider recruitment and contracting for all provider types, contracting and credentialing timing and sequencing, and network capacity of HCBS providers.
- Lacked sufficient detail and raised areas of concern about the MCO's approach to addressing workforce development and challenges for HCBS and behavioral health services, including reliance on subcontractors, viability of virtual clinical supervision, and lack of strategies to improve the behavioral health workforce in rural and frontier areas.
- Lacked sufficient detail on encouraging provider network participation, improving provider experience, reducing administrative burden, and addressing recruitment in rural and frontier areas.
- Lacked detail and did not fully address the MCO's approach to identifying, coordinating, and addressing member/family needs in response to the case scenarios involving the adult member on the IDD HCBS waiver, member with traumatic brain injury, incarcerated member, child member with IDD and behavioral health needs, and dual eligible member.
- Lacked detail and did not fully address the case scenario involving the hospital executive's concern about psychiatric boarding.

UCare Kansas, Inc.

Strengths

- Strong approach to encouraging provider network participation, including provider outreach, contracting, and multiple strategies to reduce provider administrative burden.

Weaknesses

- Limited (one example) Medicaid managed care experience in providing similar services to services provided in the KanCare program.
- Limited information about the MCO's approach to improving timely completion of member health screens, including a lack of detail regarding member contact and engagement, use of incentives, and how the MCO's screening will improve the program.

- Lacked sufficient detail on the MCO's approach to serving as an effective partner with the State and other stakeholders and provided limited information on how to resolve common provider issues.
- Lacked detail to sufficiently describe approach to encouraging and engaging members to actively participate in their health care.
- Did not sufficiently describe the MCO's approach to soliciting feedback from members/families and using feedback to improve member/family experience and the KanCare program.
- Lacked detailed strategies for updating and maintaining the provider directory, ensuring directory accuracy, and addressing provider burden regarding directory information.
- Did not sufficiently describe the MCO's approach to building capacity or using CHWs and CHRs, nor how the MCO will evaluate the CHWs/CHRs effectiveness in fulfilling their roles.
- Did not provide sufficient detail about the MCO's approach to advancing and monitoring integrated, whole-person care.
- Did not provide sufficient detail describing the MCO's capabilities and approach to screening, identifying, and using a closed-loop referral system to meet members' SDOH needs.
- Did not sufficiently describe the MCO's approach to ensuring appropriate utilization of services while reducing provider administrative burden.
- Did not sufficiently describe the MCO's approach to ensuring compliance of the MCO's UM program with MHPAEA.
- Lacked detail regarding the MCO's approach to collaborating with the State on pharmaceutical initiatives and best practices, including the role of the pharmacy director and information regarding fraud, waste, and abuse prevention.
- Provided minimal information about member access and availability of NEMT services.
- Lacked details on the MCO's capability and approach to providing and evaluating the effectiveness of the MCO's behavioral health crisis services.
- Did not include sufficient detail to demonstrate the MCO's approach and experience related to increasing the provision of tobacco screening and cessation.
- Did not provide sufficient information or description of the MCO's approach to developing a quality management program that drives a program-wide culture of continuous quality improvement.
- Did not include sufficient details on identifying and addressing HCBS service gaps, including providing limited to no detail on monitoring gaps.
- Lacked detail and did not fully address approach to identifying, coordinating, and addressing member/family needs in response to all member-specific case scenarios.
- Did not provide sufficient detail on the MCO's approach to the case scenario regarding the hospital executive's concerns about psychiatric boarding, including the lack of an identified timeframe for follow-up activities.

IV. PNC Request for Release of Cost Proposals

Consistent with RFP Section 5.2 F, as a result of the PNC's review of the information in the technical evaluation report, the PNC requests OPC to release the cost proposals for Sunflower, United HealthCare, Aetna, Healthy Blue and CareSource Health Plan.

Attachment 1: KanCare RFP Rating Scale and Definitions

Rating Scale	Definition	Notes	% of Points
5	The response is excellent. The response fully addresses the technical question and associated RFP requirements and demonstrates superior method of approach, capabilities, and/or experience, as applicable to the question.	To support a five (5) rating, the evaluator must document that the response demonstrates: • A method of approach that is highly desirable to the State and represents best practice or innovation in many areas of the response. The description is detailed enough to determine that the approach is viable, geographically appropriate (when necessary) and describes how the Bidder will meet or exceed the requirements in the RFP; and/or • Highly desirable capabilities that are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, information technology (IT) systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet or exceed the requirements in the RFP; and/or • Extensive experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses.	100%
4	The response is very good. The response fully addresses the technical question and associated RFP requirements and demonstrates excellence in method of approach, capabilities and/or experience, as applicable to the question.	To support a four (4) rating, the evaluator must document that the response demonstrates: • A method of approach that is desirable to the State and represents best practice or innovation in some areas of the response. The description is detailed enough to determine that the approach is viable, geographically appropriate (when necessary) and describes how the Bidder will meet or exceed the requirements in the RFP; and/or	75%

Rating Scale	Definition	Notes	% of Points
		• Desirable capabilities that are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet or exceed the requirements in the RFP; and/or • Relevant experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses.	
3	The response is good. The response fully or nearly fully addresses the technical question and associated RFP requirements and adequately demonstrates the method of approach, capabilities and/or experience, as applicable to the questions.	To support a three (3) rating, the evaluator must document that the response demonstrates: • A method of approach that is desirable to the State and includes a description with enough detail to determine that the approach is viable and geographically appropriate (when necessary) and describes how the Bidder will meet the requirements in the RFP; and/or • Adequate capabilities are either currently in place or that will be implemented in accordance with a detailed and viable description of how the Bidder will develop the capabilities. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • Some experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and • The response has no significant weaknesses but may have minor weaknesses that can be reasonably overcome.	50%

Rating Scale	Definition	Notes	% of Points
2	The response is minimally acceptable. The response does not fully address the technical question and/or associated RFP requirements, or does not sufficiently demonstrate the method of approach, capabilities, and/or experience, as applicable to the question.	To support a two (2) rating, the evaluator must document that the response demonstrates: • A method of approach that is not desirable to the State, lacks enough detail to determine that the approach is viable and geographically appropriate (when necessary), and/or does not describe how the Bidder will meet the requirements in the RFP; and/or • Some capabilities offered are insufficient, do not appear to be viable; or the response lacked sufficient detail to describe how the Bidder will develop the capabilities to meet the requirements of the RFP. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • Some, but limited, experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and/or • The response has a significant weakness or a number of weaknesses and/or a number of minor weaknesses that will be difficult to overcome.	25%

Rating Scale	Definition	Notes	% of Points
1	The response is poor or unacceptable. The response fails to address most elements of the technical question and/or associated RFP requirements, fails to demonstrate the method of approach, capabilities, and/or experience as applicable to the question, or no response was provided.	To support a one (1) rating, the evaluator must document that the response demonstrates: • A method of approach that lacks enough detail to evaluate how the Bidder will meet the requirements in the RFP and/or that violates the requirements in the RFP; and/or • Most or all capabilities offered are insufficient or do not appear to be viable and/or the response lacks enough detail to evaluate how the Bidder will develop the capabilities to meet the requirements in the RFP. Capabilities include organizational infrastructure and resources such as staffing resources, established protocols, IT systems and system capabilities, organizational structure, technology, operational infrastructure necessary to meet the requirements in the RFP; and/or • A lack of relevant experience performing similar work to that required in the RFP and with similar populations, program size, and covered services; and/or • The response has significant weakness that cannot be overcome and/or a large number of minor weaknesses; and/or • The Bidder did not provide a response to the question.	0%

EXHIBIT
3

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

KanCare Medicaid & CHIP Capitated Managed Care

RFP EVT0009267

Follow up Questions for CareSource:

Q.1. Can you describe your organization's strategy and preparedness to meet the diverse needs of the HCBS population, specifically addressing how you will ensure person-centered planning, promote community integration, safeguard against institutionalization, and ensure an adequate HCBS network? Please include examples of tools, resources, and partnerships you will utilize to support this population, with a focus on those members who are most difficult to serve.

A.1.

Q.2. How will your organization ensure and promote compliance with the HCBS Final Settings Rule, ensuring that all settings where HCBS are provided meet the criteria for being integrated in and support full access to the greater community? Please detail the process for evaluating current settings, implementing, and supporting necessary modifications where warranted, and monitoring ongoing compliance with the rule.

A.2.

Q.3. Can you describe specific efforts you plan to execute to address workforce shortages in Kansas, including specific workforce development strategies. Be specific as to the priority practitioners your focus will be on, and how you will address specific gaps in rural and frontier areas.

A.3.

Q.4. Describe how you would identify HCBS service gaps to ensure authorized services are provided to members. How would you then address such gaps, particularly in areas of the state where self-direction may be the only option.

A.4.

Q.5. Further describe the approach CareSource will utilize to advance integrated whole-person care. Specifically describe the role of incentives and value-based purchasing. How will your approaches address cultural, linguistic or health literacy needs? Finally, how will you know if your approaches are effective.

A.5.

Q.6. Describe ways in which you would reduce the administrative burden on providers and streamline processes with regard to utilization management. What processes do you have in place to assure that providers will have a true peer (i.e. same specialty) when appealing a decision?

A.6.

Q.7. How will you ensure compliance with access and service standards for Non-Emergency Medical Transportation? How will all members be aware of how to access such transportation, including urgent needs? How will you measure effectiveness of this service?

A.7.

Q.8. Provide specific details on your recruitment and contracting strategies to develop a provider network. How is that process different for varying provider types? Describe the current status of your network, including the current numbers and letters of intent by provider type.

A.8.

Q.9. Please elaborate on specific strategies you will deploy to address the dental services gap Kansas has in the Medicaid population, particularly in the rural and frontier areas.

A.9.

Q.10. Please describe how the members in the health alliance model would be structured/work coordinated, including what level of staff would have ultimate accountability for them. Also, describe how you would address potential conflicts of interest.

A.10.

Q.11. With the health alliance model, please provide an outline of the approach you would take to assure all information technology systems are integrated and tested for readiness for a January 1, 2025, go-live. Please briefly describe the “modern” data platform that is mentioned in the bid response.

A.11.

Q.12. Please outline the criteria you use to determine the placement of Community Health Workers. Please describe how you will collaborate with the Medicaid team on Community Health Worker strategies/deployment?

A.12.

Q.13. Please elaborate on how you will contribute to and support the state in creating and publishing a timely and user-friendly dashboard of meaningful metrics for members and stakeholders of the Medicaid program.

A.13.

Q.14. Noncompliance reported in your bid noted areas where a pattern of issues occurred with reporting. Please elaborate on changes you have recently made to improve in this area.

A.14.

Q.15. Noncompliance reported in your bid noted data breaches through a number of your subcontractors. Please elaborate on changes you have recently made to improve in this area.

A.15.

Q.16. Prior authorization difficulties are a common theme amongst Medicaid stakeholders. Please elaborate on the top 2-3 items that you are focused on related to improving the Prior Authorization Process, including changes you feel the state could make to help you achieve your goals.

A.16.

EXHIBIT
4

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

KanCare Medicaid & CHIP Capitated Managed Care

RFP EVT0009267

Follow up Questions for Healthy Blue:

Q.1. Can you describe your organization's strategy and preparedness to meet the diverse needs of the HCBS population, specifically addressing how you will ensure person-centered planning, promote community integration, safeguard against institutionalization, and ensure an adequate HCBS network? Please include examples of tools, resources, and partnerships you will utilize to support this population, with a focus on those members who are most difficult to serve.

A.1.

Q.2. How will your organization ensure and promote compliance with the HCBS Final Settings Rule, ensuring that all settings where HCBS are provided meet the criteria for being integrated in and support full access to the greater community? Please detail the process for evaluating current settings, implementing, and supporting necessary modifications where warranted, and monitoring ongoing compliance with the rule.

A.2.

Q.3. Can you describe specific efforts you plan to execute to address workforce shortages in Kansas, including specific workforce development strategies. Be specific as to the priority practitioners your focus will be on, and how you will address specific gaps in rural and frontier areas.

A.3.

Q.4. Describe how you would identify HCBS service gaps to ensure authorized services are provided to members. How would you then address such gaps, particularly in areas of the state where self-direction may be the only option.

A.4.

Q.5. With the vast number of benefits described that the plan provides, what is your approach to tailoring discussions with members to what is most appropriate to their needs?

A.5.

Q.6. Describe how community care coordination would be integrated with your overall model of care. Specifically address roles, responsibilities, and care coordination oversight

A.6.

Q.7. Please elaborate on how you would improve in addressing patients who frequent the emergency room, focusing on your discharge planning process and methods to redirect these patients to other sites of care.

A.7.

Q.8. Describe your plan to have a robust network of providers in place by January 1, 2025, to support consumers receiving services under the state's Home and Community Based Services, with a particular emphasis on the direct care workforce, and specialized in-home nursing services.

A.8.

Q.9. Please outline the criteria you use to determine the placement of Community Health Workers. Please describe how you will collaborate with the Medicaid team on Community Health Worker strategies/deployment?

A.9.

Q.10. In regard to Utilization Management, what processes do you have in place to assure that providers will have a true peer (i.e. same specialty) when appealing a decision?

A.10.

Q.11. Please elaborate on how you will contribute to and support the state in creating and publishing a timely and user-friendly dashboard of meaningful metrics for members and stakeholders of the Medicaid program.

A.11.

Q.12. Noncompliance reported in your bid response noted areas where a pattern of issues occurred with the timeliness and accuracy of encounter submissions. Please elaborate on changes you have recently made to improve in this area.

A.12.

Q.13. Please elaborate on how you remedied the transportation issues experienced in Kentucky.

A.13.

Q.14. Prior authorization difficulties are a common theme amongst Medicaid stakeholders. Please elaborate on the top 2-3 items that you are focused on related to improving the Prior Authorization Process, including changes you feel the state could make to help you achieve your goals.

A.14.

EXHIBIT
5

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

KanCare Medicaid & CHIP Capitated Managed Care

RFP EVT0009267

Follow up Questions for CareSource:

Q.1. Can you describe your organization's strategy and preparedness to meet the diverse needs of the HCBS population, specifically addressing how you will ensure person-centered planning, promote community integration, safeguard against institutionalization, and ensure an adequate HCBS network? Please include examples of tools, resources, and partnerships you will utilize to support this population, with a focus on those members who are most difficult to serve.

A.1.

Strategy and Preparedness

CareSource Kansas (CareSource) understands the diverse needs of both children and adults in HCBS populations across the nation and those served by the seven waiver programs in Kansas. We recognize those most difficult to serve are often Members with IDD that have behavioral health complexities and children in the child welfare system with challenges being supported in the least restrictive setting. Our strategy to meet these needs contains the following core elements:

- Unique Kansas-based partnerships through the CareSource HealthAlliance (the HealthAlliance)
- Direct support and oversight for Community-based Care Coordinators (CCC) assigned to each HCBS Member
- Advanced technology solutions that streamline person-centered planning and address rising risk

We believe that Members, families, and Providers, properly supported by CCCs, served by trusted local community partners, and empowered by person-centered tools and technology available 24/7/365, can improve health outcomes and offset growing workforce challenges. This support allows HCBS Members to maintain their natural supports in the least restrictive environment appropriate for their care needs.

CareSource's preparedness to meet Kansas HCBS needs is evidenced by **over 30 years of providing managed care services for complex populations** and the work of CareSource's local Kansas-based team that **began nearly three years ago coupling CareSource's HCBS technology innovations with our HealthAlliance Partners' direct service capabilities.** Ninety percent (90%) of our business is exclusively focused on Medicaid and complex populations and continues to expand as states choose CareSource as a partner to solve complex care needs. One example is our Arkansas Provider-led Arkansas Shared Savings Entity (PASSE) which covers the health care for Arkansans who have a behavioral condition or an IDD. Our HCBS experience and current operations range from fully integrated managed LTSS, to provider Provider-led LTSS programs, to FFS LTSS waiver administration for state agencies. We also provide LTSS technical assistance, QI, and staffing support to Frail Elders, IDD, and other complex care populations nationally. This diversity in HCBS program design and implementation

prepares us to partner with each individual state and program, and our preparedness is proven by our performance. For example, our Ohio program, which serves the HCBS population, was **recently recognized as the top-rated health plan in the state**, and **one of the top three performing plans in the country** based on our CAHPS® survey results.

Ensuring Person-Centered Service Planning

We ensure person-centered planning by investing in and continuously refining the following:

- Proprietary HCBS care coordination model
- Automated care planning tools
- 24/7/365 support

Through our experience and in partnership with our Kansas-based HealthAlliance Partners and national experts,

[redacted]

Within 24 hours of enrollment, Members are assigned to a CCC who conducts initial telephonic Member outreach to schedule a face-to-face visit as soon as the Member and/or their representative is available. For HCBS Members that require alternative methods beyond the initial phone outreach, we employ a variety of engagement strategies in coordination with our HealthAlliance Partners (e.g., contract with established Providers, street outreach for Members experiencing housing insecurity, and local CHWs). This ensures that Care Coordinators can work efficiently and at the top of their license. We ensure Members and their representatives know they can request alternative modes for assessments tailored to fit their preferred choice and their lives (e.g., telephone, virtual visit, or settings other than the Member's residence or service location). When possible, and with the Member's consent, the Care Coordinator works with the Member and their circle of support, informal and formal caregivers, legally authorized

representative, or other Member-identified individuals to conduct the comprehensive assessment in a setting convenient to the Member and their supports.

[redacted]

Member PCSPs include customized strategies and services based on each Member's needs, including covered and value-added preventative benefits and informal supports and services to address SDOH and care gaps proactively and avoid unnecessary or costly services not aligned with Member preferences or goals. [redacted] Once the Member and their support team have developed an initial PCSP, the Care Coordinator continues collaborations to confirm Member choice of Providers and their choice to self-direct their care, as well as communicates with each Provider to discuss and coordinate specific services they provide to assure seamless service delivery and continuity. While vetting and solidifying the Member's preferred Providers, the Care Coordinator shares information (at the approval/discretion of the Member) about communication and support preferences so Providers can learn the Member's qualities, interests, strengths, goals, and preferences to better support them in the community.

Care Coordinators are trained to develop PCSPs written in plain, direct language and accessible to IDD and persons who have LEP, consistent with 42 CFR §435.905(b). CCCs will also have training on the NCQA PCOMs and CareSource will work with them to ensure those elements are met. The assigned Care Coordinator monitors goal progression based on the NCQA PCOM goal attainment scale and works with the Member to update the PCSP, address barriers, and ensure the frequency of updates is based on the Member's needs. Depending on Member preferences, we immediately provide an initial printed copy or digital access through the Member portal of updated PCSPs as they are developed.

[redacted]

[redacted]

Promoting Community Integration

CareSource is dedicated to supporting and advancing community integration and the full inclusion of all KanCare Members. We demonstrate this commitment by ensuring Members have access to the full spectrum of social, educational, and employment opportunities embedded in their communities through a localized grassroots approach to collaborate with key local partnerships. This includes our HealthAlliance Partners, Kansas Providers, Kansas advocacy groups (e.g., KACIL, KCDD, SACK, Brain Injury Association of Kansas and Greater Kansas City, etc.), and community-based organizations. We recognize these partnerships are important in supporting Members as they pursue their interests, desires, and goals, which includes control over their own day and choice to receive services in the most integrated setting appropriate to their needs. As an example, CareSource has partnered with Kansas University Center on Developmental Disabilities to use the Self-Determination Inventory: Adult Report to support a Member's choice to increase self-direction skills to live independently in their home and community.

At the core of our commitment to promoting community integration is person-centered care. We support Members' choice and elevate their voice in developing their comprehensive PCSP. We will work with CCCs and Targeted Case Managers to help Members discover their unique opportunities, design their individualized goals, and choose who they want to participate in the meeting. To strengthen person-centered planning principles, CareSource will work with UMKC to deliver and make available Charting the LifeCourse trainings for Members, CCCs, Targeted Case Managers, and service Providers.

CareSource recognizes the importance of investing and expanding access to critical HCBS services and supports, such as supported employment, accessible community-integrated housing options, assistive technologies, and transportation to promoting community integration and greater independence. [redacted]

Safeguarding Against Institutionalization

All LTSS Members have the right to receive person-centered services that support them to live, contribute, and thrive in their homes, families, and communities. CareSource ensures this right by embedding community transition services at the core of our person-centered planning process and model of care. In one MLTSS program alone, CareSource has consistently rebalanced nursing facility enrollment to HCBS by more than 3% each year over a 10-year period. Supporting existing community-based Members to remain in their home is equally as important as successful transitions to the community. Our focus on successful community transitions and sustained nursing home diversion has led to **over 98% of our community-based Members aging-in-place and remaining safely in the community** and resulted in CareSource as the #1 Plan in Ohio for minimizing institutional length of stay. Successful transition and diversion services begin with supporting nursing facilities through collaborative partnerships. We use advanced MDS analytics technology in

partnership with skilled nursing facilities to identify potential safe transitions and increase the success of Members returning to the community. CareSource partners with nursing home Providers using methods such as VBP to align incentives and improve outcomes for Members while increasing Provider viability.

[redacted] MDS Member-level risk scoring allows Members, Providers, and CareSource to make data-driven decisions on when Members can safely transition to a community setting of their choice.

Once transition Members are identified and they confirm their desire to move to the community, CareSource coordinates services, including but not limited to the following:

- **Home Modification:** If the Member needs home modification for a safe transfer back to their home or community, a physical or occupational therapist home inspection helps identify the modifications needed. Modifications may include the installation of ramps and grab bars, widening of doorways, modification of bathrooms and kitchens, and specialized electric and plumbing. We partner with community-based organizations to provide critical home repairs, energy conservation, lead poisoning prevention, accessibility modifications services, and community classes on fall prevention and how to stay safe and healthy at home.

- **Transportation:** In addition to the non-emergency transportation benefit, CareSource will cover and help Members plan and schedule transportation to and from specific locations or events. Examples include grocery stores, community, and religious activities, etc.

- **Trial Visits to the Community:** Based on Member preference and informed choice, trial visits may occur before a Member's return to the community. We offer initiatives like "Home for the Holidays" transportation benefit, which encourages this process for the value it can bring to the Member enabling preparation, readiness, and a greater understanding of the transition. This process can further highlight needs that may not have been as apparent in the assessment process while in an institutional level of care. CareSource is committed to deploying all necessary strategies to ensure a successful transition and ensuring Member's needs, preferences, and choices are considered, allowing them the opportunity to live fulfilling lives while experiencing optimal social inclusion and community belonging.

- **Employment:** When a Member seeks employment, we provide the opportunity to collaborate with our HealthAlliance Partners. InterHab and Association of Community Mental Health Centers of Kansas (ACMHCK), who are both recognized leaders in integrated employment best practices, can assist Members with accessing innovative employment supports.

- **Housing:** Housing options and availability are essential for a successful transition. To supplement the housing supply, CareSource created the **CareSource FastTrack Housing Program,** offering Members with a desire and clinical readiness to live outside of the institutional care setting options to move to the community safely and expeditiously. Our housing investments in Kansas offer temporary housing options until permanent housing is available. Included in our housing program, our CareSource team utilizes CareSource Life Services® (see below for more detail) and identifies and works through the obstacles of securing affordable, accessible, sustainable, and permanent supportive housing. This model combines federal housing vouchers and Fair Housing Act programs with comprehensive Medicaid HCBS waivers and other community-based resources. Our team of

licensed clinicians, housing team specialists, and peer supports work together for a safe and smooth transition to the community. Our process includes administrative support such as review of lease, purchasing items needed for transition, coordinating home modifications, utilities, arranging for transportation to view housing options, assisting with completing applications, assistance to secure household furnishings and goods, and move coordination. Our Housing team attends local or federal housing initiative meetings and engages private market landowners for recruitment and retention to develop housing stock. CareSource is working with the Kansas Statewide Homeless Coalition, the Kansas Housing Resource Corporation (KHRC) and the five Continuums of Care to integrate healthcare and housing. Our Care Coordinators and Housing Lead work with community-based organizations to assist with coordinated entry assessments and housing first strategies. Our relationship with the KHRC and financial support will reinstate a statewide housing locator tool linking landlords with housing agencies to Members. We will also utilize the strength of our HealthAlliance Partners who are skilled at permanent supportive housing, housing adults with disabilities, and transitional aged youth.

- **CareSource Life Services:** CareSource Life Services incorporates a suite of services designed to address and eliminate the socioeconomic barriers that Members often experience, such as access to nutrition, affordable housing, transportation, education, legal assistance, and sustained employment. These services include:
  - ***CareSource HousingConnect,*** a comprehensive strategy to address housing insecurity and affordability
  - ***CareSource FoodConnect,*** a triple-aimed strategy focused on decreasing food insecurity by connecting Members to food pantries, information about state programs (SNAP, WIC), food clinics, farmers' markets and other community-based organizations that assist with food,
  - ***CareSource JobConnect*** to foster personal responsibility and healthy lifestyles
  - ***C*areSource PeerConnect,** a multi-pronged strategy to increase the use of certified Peer Support Specialists to assist our complex health population

Ensuring an Adequate HCBS Network

For over 30 years, we have been building and supporting high-quality comprehensive Provider networks across the country to serve our Members at every point along the care continuum. We will ensure an adequate HCBS network by combining our national HCBS network engagement experience with our:

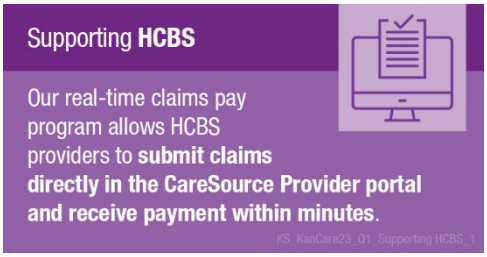
- Unique and strategic community-based partnerships in Kansas
- Investment in provider supportive technology
- Support of provider workforce development

We leveraged our HealthAlliance partnership with InterHab (IDD Providers), ACMHCK (behavioral health centers), and the Children's Alliance (children's mental health and child welfare service Providers), as well as MOUs with KACIL (persons seeking to regain independence) and k4ad (vulnerable older adults), to build and continue to grow a HCBS Provider network that will empower our KanCare Members. Each of our community partners has unique and valuable insights that span the HCBS network continuum from children to adults and have guided us in understanding local challenges, opportunities, and unique considerations while supporting the development of strong relationships with these Providers. Additionally, we launched CareSource Community of Innovation on February 6, 2024, to support innovation development driven by Providers themselves. Moreover, our HealthAlliance Partners have been working with CareSource in developing alternative payment methodologies, VBP programs, accreditation standards, standard quality measures, SDOH, and other arrangements to elevate the payor-Provider experience.

For example, as part of our collaboration with InterHab, we heard that HCBS Providers are asked to contract with MCOs via contract templates that may speak well to services offered by hospitals and physician groups but fall short of meeting the needs of the HCBS Provider community. Therefore, we worked closely with InterHab to develop a customized contract template for HCBS Providers to accommodate the differences in the robust services offered by these critical Provider types and streamline our contracting process. With consultation from our HealthAlliance Partners, CareSource has developed VBPs for Providers that historically had not been offered such arrangements by other Kansas MCOs. In these ways, they will be key collaborators in ensuring we offer a best-in-class Provider experience for all Kansas Providers.

While our Kansas Provider network currently [redacted] we recognize that an effective HCBS network must continue to add innovative Providers that Members with special health care needs may choose to receive services. Our commitment to ensuring continuity of care at program transition, adequate Provider capacity, and Member choice to live full lives in their community with support to age-in-place drives our approach to continuing to build a high-quality network. To ensure continuity of care for Members, and to ease Provider transition and reduce administrative burden, **we will contract with any willing HCBS licensed Provider who can meet credentialing requirements** prior to the KanCare go-live. Once contracted, we will partner with each Provider to supply education and training and ensure each Provider meets or exceeds compliance and quality standards. If a Provider does not meet these standards, we will support them in remediation efforts with technical assistance and provide education to ensure Member safety and quality of care. CareSource does not simply pass over Providers who may need assistance navigating a complex regulatory environment but will provide the tools necessary to ensure the most accessible network possible for our Members.

We have dedicated teams of experts that serve and support each unique Provider type, including HCBS. Our commitment to network development, Provider engagement and support is shown in the Provider feedback survey results we routinely receive. **CareSource leads other MCOs for Provider Satisfaction in the states we serve, including having the highest Provider Satisfaction rates for three years running**. We look forward to bringing this experience, rapport, and support to all HCBS Providers in Kansas.



CareSource operates more efficiently than most large managed care companies allowing us to better serve our Provider partners. Our nonprofit status allows us to invest more in state-of-the-art specialized technology, which improves access for Members and increases capacity for Providers. The heart of our success is our ability to automate the basics, such as real-time authorization support and rapid claims processing. Our CareSource Provider portal allows 24/7/365 claims entry and process **payments to Providers within minutes.** We provide immediate claims payment to HCBS Providers to maintain their direct care workforce. Using our **real-time claims payment feature**, Providers submit claims for immediate processing and receive payment within minutes. This allows Providers to focus on caring for Members rather than focusing time and resources on complicated claims submission processes and worrying about timely payments.

Q.2. How will your organization ensure and promote compliance with the HCBS Final Settings Rule, ensuring that all settings where HCBS are provided meet the criteria for being integrated in and support full access to the greater community? Please detail the process for evaluating current settings, implementing, and supporting necessary modifications where warranted, and monitoring ongoing compliance with the rule.

A.2.

The HCBS Final Settings Rule (Rule) sought to guarantee rights to all persons receiving Medicaid HCBS, recognizing that for too long many people with disabilities and those needing LTSS have been deprived basic features of community life that most Americans are able to take for granted. **CareSource has unique experience in this area and stands ready to collaborate** closely with all stakeholders to implement both the requirements and the spirit of the HCBS Final Settings Rule throughout our work.

CareSource's Approach to Ensuring and Promoting Compliance

As noted in our response to A.1., CareSource is uniquely situated to support Kansas by ensuring that all HCBS settings meet the criteria for being integrated in and support full access to the greater community. The **CareSource HealthAlliance** (which represents a considerable number of HCBS Providers in Kansas today) is a perfect venue for promotion of the Rule information/education and we will deploy several strategies and rigor to ensure and promote compliance with the Rule.

Ensuring Full Access to HCBS to the Greater Community

[redacted]

We placed particular emphasis on supporting people with disabilities to reside in non-Provider-owned and controlled **residential** settings, an objective supported by the Rule's greater regulatory requirements for Provider-owned or controlled residential settings. CareSource will work closely with the State to identify settings that require heightened scrutiny review to be appropriately funded as HCBS and to work to achieve necessary remediation to ensure compliance with the Rule.

Moving the Needle on Autonomy and Independence

The Roommate Housing Program is a **cutting-edge model designed to enhance the lives of individuals with intellectual and developmental disabilities by promoting greater independence within the community through shared living arrangements.** This unique program, which officially launched in October of 2023, employs a tailored housing and matching process utilizing smart home technology.

In partnership with Easterseals in Arkansas, we aim to **foster independent living for adults with disabilities** through the Roommate Housing Program. The organization hosted a ribbon-cutting ceremony and open house with CareSource PASSE at the Palisades at Chenal Valley, marking the formal celebration of this initiative.

KS_KanCare23_Moving the Needle_2

The Rule also indicates that HCBS should provide people with disabilities with opportunities to seek **employment** and work in competitive integrated settings. CareSource has devoted substantial attention towards expanding the availability of and enhancing supported employment services in our work and is prepared to invest further in that capacity within Kansas.

Meaningful and **Integrated** Employment Today

CareSource's commitment to supported employment in Kansas can be seen through our support to expand the number of participating supported employment Providers in the Kansas Employment First Grant Pilot through the University of Kansas Center on Developmental Disabilities, University of Kansas Institute for Health and Disability Policy Studies, and the Washington Institute on Supported Employment (WISE). **This program will help assist Providers to expand their capacity to provide competitive, integrated employment opportunities for Kansans with disabilities.** The Providers will be paired 1:1 with a Mentor Organization that has undergone a similar transformation, and they will have the opportunity to participate in evidence-based, ACRE accredited training opportunities through WISE so that their staff can provide state of the art competitive, integrated employment supports and services.

CareSource will be working with Dr. Lisa Mills, a respected leader in HCBS system transformation, to increase competitive integrated employment opportunities and outcomes. **The initiative will focus on collaboration with service Providers and funding partners to build innovative approaches that reflect recognized best practices.**

KS _ KanCare_Q2_Meaningful and Integrated Employment Today_3

Ensuring and Promoting Compliance Through Person-Centered Service Planning

Compliance starts with each Member understanding their choices and understanding they have access to the same kind of choice regarding services and supports, who supports them, and where they receive their services. We strongly believe that adherence to the Rule requirement starts with the person-centered service planning process and help to ensure the PCSP reflects the Member's vision for a good life, and this absolutely includes choice of setting. We train and regularly re-train all CareSource staff and CCCs serving Kansas Members on the Rule, and we ensure Providers also comply with the Rule through audits, onsite visits, and Member reports as outlined below.

We develop PCSPs in collaboration with the Member, caregivers, and their chosen Integrated Care Team (ICT). ICTs must genuinely and comprehensively reflect Member choice, strengths, needs, barriers, goals, and identified resources to ensure well-being and optimal health outcomes. CareSource's MLTSS Program Plan Training and Auditing team will perform monthly random audits and schedule Care Coordinators to present case details at conferences for quality assurance and learning collaboration to improve Member outcomes. We will conduct audits of selected reports which include PCSPs when appropriate. Our audits verify the accuracy, completeness, and timeliness of case documentation and updates. We will submit our sampling methodology and protocols to the State for approval, which will account for a mix of PCSPs.

In addition, we will conduct additional reviews and audits on PCSPs that indicate a modification to the additional requirements of Provider-owned or controlled residential settings articulated in 42 CFR §441.301(c)(4)(vi) to ensure compliance with 42 CFR §441.301(c)(4)(vi)(4).

Care Coordination

The Care Coordination team, comprised of the MCO Care Coordinator and the CCC or Targeted Case Manager, will address issues regarding Provider ongoing compliance with the federal HCBS Settings criteria within 30 days of discovery. During the scheduled contact with the Member, the Care Coordination team will complete the HRA, PCSP, and environment survey ensuring compliance of the Rule. The assessments and survey will evaluate if the current Provider meets the federal HCBS Settings criteria (new Provider if in transition) and ensure the Member's preferences and supports and services are followed. If the Member reports any issues that may signify Provider non-compliance with one or more federal HCBS Settings criteria, the Care Coordinator will confirm the information the Member has shared

through a masked inquiry to protect the Member's privacy. If the Care Coordinator determines the Provider is not compliant with the federal HCBS Settings criteria or is not meeting the service needs committed to as part of the Member's PCSP, the Care Coordinator will immediately report the non-compliance to CareSource's Quality Assurance team and KDADS HCBS Program Integrity and Compliance (PIC) Unit for analysis and system compliance reporting. The team will arrange to meet with the Provider to develop and implement a CAP. We will incorporate onsite compliance reviews as part of our annual quality assurance audits and will document and share data relevant to ongoing compliance with KDADS' HCBS PIC Unit. We will note any areas of non-compliance with the federal HCBS Settings criteria, establish a CAP, and provide technical assistance to help the Provider achieve compliance. We will also conduct required training biannually for all network LTSS Providers to ensure leaders, Direct Support Professionals (DSP), and Provider entities understand federal HCBS Settings requirements.

Person-Centered Service Planning

You cannot advance human rights, choice, autonomy, and integration without an intentional person-centered philosophy and culture. A framework begins with the understanding that all people have the right to live, love, work, play, experience good health, and pursue their aspirations in vibrant, diverse, and inclusive communities. We are excited to support KDADS in the process of revising the PCSP policies and processes, specifically the universal options counseling form and the inclusion of the participant survey questions and the commitment to ensuring that all participants' services are tailored to their unique needs, preferences, and goals, emphasizing their right to direct their services and participate fully in their communities.

[redacted]

Ensuring and Promoting Compliance Through Provider Support

We collaborate with Providers to ensure a supportive method for validation of existing PCSPs and assessing new and continued authorizations. We work in real-time to ensure Providers have what they need to continue providing the supports and services to our Members. We build our strategy to engage with the Provider continuum, including institutions and HCBS Providers, based on our experience in working with these groups to implement LTSS services in multiple states, including Ohio and Arkansas, as well as through our **affiliate, Columbus, which brings robust HCBS FFS care coordination experience to CareSource as it serves** Georgia, Indiana, Delaware, Florida, New Jersey, Kentucky, South Carolina, and New Mexico. Moreover, it also provides **HCBS QI service programs in** Alabama, Arizona, California, Iowa, Missouri, New Mexico, Pennsylvania, and Washington D.C. To foster Provider collaboration, we promote bi-directional communication with 24/7/365 access, and commit to engaging Providers to ensure we hear their voices and demonstrate, through action, that we value their expertise. We tailor our Provider portal experience to our LTSS Providers for ease of claims submission and review of PCSPs. We further align our Provider supports and our Provider portal with industry standards for LTSS claims submission processes and service authorizations to increase ease for all involved.

Ensuring and Promoting Compliance Through QI Monitoring
To ensure our care coordination program performs at the highest standards, CareSource's Quality staff conducts monthly (or more frequently depending on findings) programmatic-level audits to ensure contractual and NCQA adherence in care coordination practices and documentation. The quality team shares audit outcomes and feedback with Care Coordination team leadership, Training teams, and staff, to find areas for improvement and implement additional education and counseling as appropriate. We conduct a formal program evaluation that includes monthly programmatic-level audits, identified barriers to program success, improvements during the year, and updates or revisions to processes and resources to address opportunities for improvement. We will measure quality through HEDIS, CAHPS®, other surveys, and NCQA audit scores to ensure our PCSPs are consistent with the MLTSS Program quality framework. We will share the evaluation findings with the Board of Directors. With KDHE and KDADS permission, we will establish VBP methodologies based on CMS HCBS measures related to service planning.

In addition, we monitor the information from our clinical platform for compliance with the Rule and this reporting is core to our critical incidents program. What is important to call out is compliance with the Rule is not and will not be "a side of the desk effort;" it will take a collective team of thought leaders committed to this effort. To that end, we have a dedicated full-time employee (FTE) who will wake up every morning with this work squarely in front of them. This FTE, who is part of our Quality Assurance team, monitors data gathered from care coordination assessments and surveys, and other outside sources. This FTE will interface with Providers to address red flags or issues related to food security, medication, privacy, and other Rule compliance. They support providers through education, share best practices, etc. This Quality Assurance FTE will work directly with KDADS HCBS PIC Unit to ensure compliance with the Rule.

CareSource's Approach to Evaluating Current Settings

The key to evaluation is ongoing meaningful collaboration with Members, Providers and State Partners ***"nothing about us without us."*** CareSource believes the solutions to better health outcomes and overall quality of life lives in our Members, their families, Providers, and communities. We evaluate current settings, through our QM and UM Programs and our ongoing engagement with Members, Families, Providers, and stakeholders. As part of this evaluation, we also look at use of restrictive measures such as restraint, seclusion, and other methods that restrict the Member from access to their community, peers, and home. CareSource will monitor and report on any restrictive actions through the AIR and follow up immediately on any concerns, including working with the Provider on other behavioral interventions.

CareSource's QM and UM Approach to Evaluation
We will collaborate with the State including the **HCBS PIC** Unit to measure the effectiveness of care coordination for the MLTSS Program and will collect and report required data to comply with the 1915(c) waiver performance measures on PCSP and the applicable requirements of the CMS Recommended HCBS Quality Measure Set. The CareSource QM/QI Committee conducts annual evaluations of the Care Coordination Program to determine overall effectiveness using key indicators and metric outcomes from qualitative measures and quantitative data to ensure outcomes of PCSPs are consistent with the program quality framework.

We will use the PCSP to input and continue authorizations and ensure we properly pay Providers during the transition and thereafter. Because we recognize that many LTSS Providers are small and cash flow is critical for their continuous operation, we provide real-time claims payment for Providers. By providing customized training on navigating our Provider portal, PA, claim submission, and payment procedures; reinforcing the need for seamless care delivery; coordinating benefits; and eliminating service duplication, we help pave the way for Providers to successfully transition.

CareSource's Member and Family Engagement Approach to Evaluation

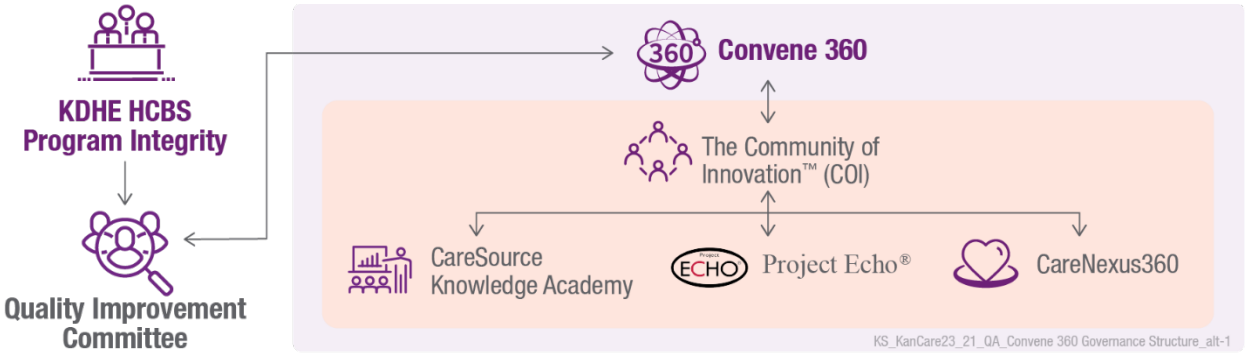
Member and family voice is core to all we do, at every step of the way. Simply asking the person receiving supports, "*Are you happy where you live, who you live with, and where you spend your day? Are you living your best life?"* is part of our everyday conversations. CareSource values input from Members, their circle of support, our Providers, and the larger community. We evaluate current HCBS through engagement with these groups to ensure our Members are receiving services in the most appropriate and least restrictive settings.

In addition, leveraging Columbus who has over a decade of experience supporting Providers and state agencies around HCBS policy including the Rule, with approval from the State, we will use the CAHPS® HCBS Survey to measure overall satisfaction with services and supports **from the perspective of individuals being supported** and served through face-to-face interviews. In addition, we will work with KDADS to develop and implement additional surveys (e.g., environmental) that assess if the current Provider meets the federal HCBS Settings criteria (new Provider if in transition) and ensure the Member's preferences and supports and services are followed. We will draw a sample of the individuals served by the Provider in each of their services. We will conduct in-person interviews with individuals in service and include a minimum of one relevant professional staff and at least one other person in the individual's life. We train all interviewers on how to conduct the interview and on the questions included in the interview tool.

At the end of the survey, reviewers conduct an exit conference where they identify both positive findings and areas in need of improvement. We will prepare a report of positive findings and areas in need of improvement to aid the Provider in addressing non-compliance. We produce monthly, quarterly, and annual reports to provide status updates and review progress. Additionally, we developed a dashboard where Members can easily review data by Provider. This data will also identify trends which we use to look at root cause and develop remediation strategies.

CareSource's Community and Stakeholder Engagement Approach to Evaluation

We ensure our stakeholders and community members have opportunities to share their input with us through a variety of mechanisms, including our Convene 360 Governance approach. Active engagement and communication with all stakeholders are key to our success. CareSource Convene 360 is our systematic approach to gather recommendations to address physical, environmental, and behavioral health gaps in care and service delivery, identify needed SDOH resources, and collaborate with the State and our HealthAlliance Partners, to best serve KanCare Members.



In addition, we are an active accessible partner, and are available 24/7/365 as needed. We are available to meet extensively with KDHE, and our executive leadership will meet monthly (or as frequently as needed) with the State to review our performance, discuss outstanding or commendable contributions, identify areas for improvement, and outline issues impacting CareSource or the LTSS Program.

CareSource's Process for Implementing and Supporting Modifications
Based on our ongoing evaluation of current settings, we can anticipate that at times, modifications will need to be made. This can apply to State level support for implementation to supporting modifications based on individual Members' current setting needs. We are well-positioned to implement and support necessary modifications in a timely manner. We utilize a comprehensive assessment in conjunction with our CCCs that is driven by the person-centered home modifications that are being requested. The CCC will also work with CareSource to complete an environmental assessment, evaluated by a physical therapist once the recommendations are made. We will also work with the AAAs in Kansas to develop the specifications for the work. Once that step is completed, an award for the modifications will be made. CareSource ensures that the modifications are made with quality and member satisfaction are met.

CareSource's Support for State Level Regulatory Compliance with Implementation
To support ongoing monitoring of compliance with the Rule, CareSource is prepared to work closely with state agencies, policymakers, the HCBS PIC Unit and advocates to identify settings in need of remediation to come into full compliance and to support them through technical assistance and additional resources to modify their service models and delivery methods to fully comply with the Rule's requirements. We stand ready to assist Kansas in facilitating full compliance with the Rule and alignment with its values of autonomy, choice and control, privacy, dignity, freedom from coercion and restraint, and other aspects of the full inclusion of people with disabilities receiving Medicaid HCBS in the broader community.

The Kansas Compliance team is integral in contractual and regulatory implementation. The team oversees all implementation and monitors with the use of metrics and compliance dashboards to ensure that regulations are timely and effectively implemented. We monitor dashboard and metrics and discuss our analyses with management and the compliance committees. On a monthly basis, we monitor timeliness and effectiveness of implementation and present these findings to management.

Olmstead Partnership

One example of how we engaged our State partners in Delaware is through our Olmstead Partnership. We were asked to assist the Division of Developmental Disabilities to conduct a comprehensive analysis of the service delivery system in the State. The focus of this effort was to **develop a response to Olmstead and a multi-year comprehensive plan for the Division.** This project included evaluation of the individuals currently being served (DC & Community), an evaluation of the waiting list, assessment of the services offered across the State, evaluation of the rate structures, a review of the Division's support and monitoring capacities, assessment of the political environment, and evaluation of the State's developmental center (current programs, services, physical condition, etc.) **This information was analyzed to identify service gaps, special population needs, revenue maximization opportunities, and alternative uses for the DC.** Findings and recommendations were condensed into a formal report that was approved by an executive task force with representatives from all affected stakeholder groups in the State. The final phase of the project involved the facilitated development of a multi-year comprehensive plan. **The plan was far reaching and outlined a 10-year plan for that will fully address the requirements of the Olmstead decision.**

KS_ KanCare_Q2_Olmstead Partnership_2

CareSource will collaborate with KDHE and KDADS to support full implementation of required quality assurance processes. This includes administering the quarterly person-centered monitoring tool, supporting implementation of the annual National Core Indicators – Aging and Disabilities survey, completing annual Provider compliance reviews, and any additional remediation activities delegated to us by KDHE and KDADS.

CareSource's Support for Members with Individual Setting Modification Needs
We are also well versed in home, vehicle, and adaptive equipment modifications to maintain or promote independence and autonomy. GuidingCare, our clinical platform, integrates assessments to trigger indicators of functional/cognitive assessment and the environmental supports to remain in setting of

choice. We collaborate with a physical therapist to assess home modification needs that will increase or maintain the independence and autonomy of the Member to remain in their setting of choice. We customize the home modifications to meet Member needs, support facilitating choice of services and who is providing home modifications. Our Home Modification Specialist assists in ensuring technical feasibility of the modification and creating specification used in the Provider bidding process.

Leveraging our Provider sourcing tool, we can load comprehensive information on home modification specifications and needs of the Member automatically to send directly to Providers in their preferred communication method. Providers can respond to the bid through the sourcing tool, and we award the bid based on quality and value to meet Member needs. Evaluating the modification process continuously through the build and including final review to ensure modification meets Member needs, specifications, and quality. Home modifications may also include the use of technology to support Members living in their setting of choice. Assistive technology also enables individuals maintain their independence by supporting daily living tasks. Smart home devices, voice assistants, and home automation systems can control lighting, temperature, and other household functions, making it easier for individuals to navigate and manage their living environment. *NOTE: We strongly believe in ensuring that all individuals are informed about the presence and use of all assistive and other technologies. This includes informed consent, notice of use, and always respecting the individual's rights and privacy in HCBS settings.*

Provider **Sourcing Tool**

In Ohio, we provide an **online Provider Sourcing tool that allows for immediate posting of services authorized on the PCSP.** This expedites services for our Members, eases the administrative burden for Providers in our request of services, and allows us to quickly culturally and linguistically align services to meet our Member's needs. The Provider Sourcing in OH is a direct result of Provider feedback derived from CareSource's Provider engagement efforts to ease Provider burden and increase the ability for more time with Members, in lieu of time spent seeking administrative approvals. **We look forward to implementing similar or new solutions to meet the needs of Kansas' LTSS Provider community.**

KS _ KanCare_Q2_Provider Sourcing Tool

CareSource's Approach to Monitoring Ongoing Compliance

We understand that evaluation and implementation are only the beginning of the process to ensure Members receiving HBCS have access to the support necessary to live a "good life." CareSource has multiple mechanisms in place to monitor ongoing compliance to the Rule, including our QM program, Member level ongoing engagement, and ongoing input from our Providers, stakeholders, and community Members.

Supporting our Kansas program, LTSS Complex Health Specialist - Community Transformation, Kyle Jones, a Wichita native with more than 30 years of experience working with all Kansas HCBS waivers. Prior to managed care, Kyle led his own case management company working with the Frail-Elderly waiver. Kyle is a member of the newly formed Kansas Council on Development Disabilities Coalition. We are invested in providing experienced resources, like Kyle, to lead and ensure compliance with the Rule and we are dedicating full time staff to focus on and serve as the single point of contact for all CareSource HCBS efforts in Kansas. CareSource will also partner with Kansas self-advocacy organizations such as the CILs, SACK, AAAs, KCDD, SILC and the Disability Rights Center of Kansas to increase awareness of the Rule requirements on the part of people with disabilities and to assist people with disabilities in filing complaints with regulators in the event of Rule non-compliance.

Monitoring Compliance Through Ongoing Member Assessment

We complete these assessments using integrated tools that align with Kansas' MFEI. We will use the MFEI outcome scales and Clinical Assessment Protocols to flag clinical issues, improve care planning and delivery of care, and provide a better quality of life. We require our Care Coordinators to assess at

least annually and during significant change events the Members living in setting of choice. We also offer tours, visits and trial runs giving people opportunities to exercise informed choice. In addition, our Care Coordinators will review the HRA, PCSP, and the HCBS criteria during each visit with our Member.

For Members who live in Provider-owned or controlled residential settings, where the Member lives in a private residence owned by an unrelated caregiver paid to provide HCBS, the Care Coordinator will document any modification of the additional conditions (under 42 CFR § 441.710(a)(1)(vi)(A) through (D)) as supported by an assessed need and justified in the Member's PCSP. In these cases, the PCSP will specify any individualized assessed need for the modification and document interventions or supports used prior to the modification. It will also document less intrusive methods of meeting Member needs that the team tried but were unsuccessful. We will document the conditions directly proportional to the specific assessed need and a schedule of contacts and time limits for periodic review of the PCSP to determine if modifications are still necessary. In all cases, we will ensure that the interventions or supports will not harm the Member. For Members who reside in a Provider-owned or controlled residential setting, the Care Coordinator will evaluate the ongoing effectiveness of any modifications and incorporate results into the Member's PCSP. We screen all Members at least annually and during each significant change event on preferred living arrangements, our Care Coordinators empower and assist Members in exercising informed choice in making decisions.

Monitoring Compliance Through Transitions of Care

During the transition from one MCO to another, we will ensure that Members can continue to receive services from their current Provider of choice to minimize service disruption and maintain established relationships for continuity. We strongly support and will promote the KDHE training that encompasses the five core characteristics of the Rule: rights, choice, privacy, autonomy, and integration. With KDHE's approval we will develop additional training opportunities to provide refresher support for existing Providers and overviews for new Providers (including contract requirements and CareSource expectations). We will participate in the Kansas learning collaboratives and conduct routine town hall meetings across the state to provide an open discussion and education on specific LTSS-focused topics customized to both HCBS and nursing facility Providers. While Providers can contact the plan through their Provider Relations Representative, [redacted] CareSource understands and acknowledges that any system change can require intense support for the Provider community and this no-wrong-door, all-hours access meets the Providers' needs and busy schedules.

Monitoring Compliance Through Ongoing Provider Support

Empowering people to live, work, and socialize in the most integrated setting is our top priority. By taking a thoughtful and intentional approach we collaborate with Providers to prioritize 'independence and integration' through targeted incentives. Recognizing the transformative power of VBP with non-traditional partners like community-based organizations, we are poised to truly impact lives. Our approach integrates cultural, linguistic, and health literacy needs, ensuring personalized care for all. Success is not just measured in metrics; it is seen in the tangible improvements in the lives of those we serve.

CareSource's experience with VBP for HCBS can also support the State's articulated priorities within the State's CAP for Rule compliance. We support Providers with respect to unbundling residential and day

services to identify non-congregate settings more clearly to comply with the Rule. By doing so we can distinguish them from congregate and Provider-owned or controlled settings that will require more intensive monitoring. CareSource will also work to collaborate closely with Providers that receive Rule grants from the State to ensure that rate-setting is calibrated to permit the ongoing and sustainable management of innovative service models most likely to comply with the Rule's requirements.

Also, we structured our Provider relations strategy to offer ombudsman-like services to Providers through our Provider Relations Representatives. Provider Relations Representatives will function as an advocate for Providers, collaborating with them no less than monthly to offer a clear avenue for voicing their concerns and needs and having their issues addressed. We will continuously monitor needs assessments for completion, accuracy, and timeliness of Provider authorizations and payments. We will establish regularly scheduled meetings on a variety of subjects and use our Provider Relations team to provide ongoing education, training, and collaboration to Providers focused on continuity of care, no disruption of service, and timely payment for services.

In addition, we will administer the Provider self-assessment tool and submit results to the State annually to ensure Providers attest to following the Rule. CareSource will partner with the State to conduct bi-annual on-site reviews to assess compliance and identify areas where additional training and technical assistance would benefit the Provider network to expand and enhance quality HCBS. We will use our Provider Review Tool for ongoing evaluation of compliance which touches on several aspects of the Rule. This review tool currently assesses the following:

- Does the Provider have a system in place to assess its compliance with the Rule?
- Does the Provider have homes that were identified as requiring Heightened Scrutiny? What is the status of these homes?
- Do any of the locations visited present as isolating individuals from the community or as a segregated setting per Rule requirements?
- Has the Provider been educating individuals on the Rule?
- What methods have been used to educate individuals?
- Are individuals able to have visitors to their home at any time?
- Does the home provide individuals with the option of a private bedroom?
- Is the Provider's setting integrated in the community?
- Does its location support full access to the greater community and engagement in community life?
- For individuals who live in Provider owned or controlled homes, do they have a lease or other legally enforceable agreement providing similar protections?

Monitoring Compliance Through Community and Stakeholder Engagement

We will leverage our Convene 360 Governance approach to help monitor ongoing compliance to the Rule by making it a standard report at all meetings and committees and will create a dashboard for transparency. In addition, we will establish daily "huddles" where we will convene external and internal stakeholders to troubleshoot in real-time, share, report, address, and resolve issues as they arise. We build trust with the LTSS community through advocacy and stakeholder meetings and cultivate and nurture relationships with the CILs, SACK, AAAs, KCDD, SILC, DRC, and other advocacy leaders. For state and local entities, we attend all regularly scheduled meetings, set up additional meetings to discuss potential partnerships, and hold community events to disseminate information and field questions. In collaboration with KDHE, we will develop a dashboard of key metrics and performance indicators that will be available to ensure a transparent and collaborative relationship every step of the way.

Q.3. Can you describe specific efforts you plan to execute to address workforce shortages in Kansas, including specific workforce development strategies. Be specific as to the priority practitioners your focus will be on, and how you will address specific gaps in rural and frontier areas.

A.3.

Workforce development is a top priority for CareSource. Through our HealthAlliance Partners, **CareSource is closer than any other MCO to this issue and developing solutions that are directly related to and informed by the specific needs of Kansas**. CareSource has long understood the importance of workforce development and is an early champion in creating opportunities for new Provider types and established Providers including those in rural and frontier areas.

We will continuously work to address Provider workforce shortages in Kansas through proven strategies. We will use data and predictive analytics to identify areas and Provider types most needed to close gaps. We work with our HealthAlliance Partners; workforce partners like Wichita State University (WSU), Mission Care Collective, and Blitz; and our in-house DSP Provider engagement team (Columbus) to sustainable solutions that address the five 'Cs of Provider workforce development (capability, capacity, connectivity, culture, and commitment). Through this data-informed, consultative approach, we develop strategies that meet the needs of metro, rural, and frontier counties. Below are our efforts to address workforce shortages in Kansas, including specific workforce strategies.

Priority Practitioners

We have been in Kansas, listening, learning, and coming alongside Providers, advocacy groups and stakeholders to get a deep understanding of the healthcare workforce gaps throughout Kansas. We utilized the following sources to inform our strategy in Kansas:

- Insights and expertise from our HealthAlliance Partners
- Insights from subject matter experts on Kansas Provider challenges
- Contract negotiations for all Provider types
- Appeals and grievances related to access to care
- Data on CHW and Peer Support Specialist challenges
- Non-traditional Provider network adequacy scan

This research and analysis, along with our experience in other states, has led us to identify the following seven priority practitioners for our focus in Kansas:

1. **DSPs:** Through insights from our HealthAlliance Partners, access to care appeals, and DSP request waitlists, we have identified DSPs as a priority practitioner focus area. Our approach to address the DSP gap in Kansas engages local colleges and universities, like WSU, to build capacity, leverages expertise with our affiliate, Columbus, to build capability and draws on partnerships with organizations, like Mission Care Collective to build a culture that will promote retention of current workers.

   CareSource supports workforce development for DSP, CHWs, and other HCBS professionals through initiatives such as our Community of Innovation and through partnerships with organizations like ***WSU***. In this partnership, CareSource supports WSU in striving to increase the professional recognition of DSPs and creating career paths including recruitment, training, retention, and advancement. The WSU badge courses provide the formal curriculum used in InterHab's "DSP+" Registered Apprenticeship Program, which provides a national apprenticeship credential through the US Department of Labor. DSP+ is made possible via a grant from the Kansas Department of Commerce. Currently, 12 IDD Provider organizations and 65 apprentice candidates are participating

in the program. This enhances the employability and upward employment trajectory of DSPs by providing training that focuses on supporting the needs of members with IDD, including vocational, educational, and career support. The expected outcomes of this collaboration include demonstration projects highlighting the lifecycle of DSP digital credentials, advancement by employers in skills-based maturity, and a reduction in open DSP positions in Kansas. The collaboration also provides knowledge about the impact of SDOH and available resources to support Members. Additionally, students review crisis intervention strategies and organizational processes for DSPs. CareSource will continue to support this work and partner closely with WSU and InterHab in efforts to expand opportunities in this and other programs. In fact, building on previous grant submissions by WSU, CareSource is exploring support of a bold new initiative to catalyze a more equitable skills-based hiring ecosystem leveraging learning and employment records.

WSU, along with employers, state agencies, and the Education Design Lab, seeks to demonstrate an end-to-end, interoperable Learning Employment Records (LER) solution using digital credentials to address a talent shortage of DSP. This project will focus on the use of LERs to attract, upskill and retain talent for DSP roles with eight badges built on open standards and designed for interoperability. This project will use open wallet specifications to issue, review, and share credentials.

WSU and CareSource will work with employers and their Human Resources departments to understand the current state of their HRIS/ATS capabilities and lead a process that enables the LER architecture necessary for employers to consume these credentials of value. DSP employers will be asked to engage in design sessions with WSU, industry associations, state agencies, HR vendors, and others to illustrate how a learner and the credential itself would move through the LER lifecycle. Also engaging employers and badge students within their organizations to understand their perspectives and needs within the LER ecosystem. Creating skills-based hiring and upskilling support for employers, this project will serve as a catalyst for proving out the “how” of alternative credential consumption.

Additionally, through our Partnership with InterHab and WSU, InterHab’s DSP+ Registered Apprenticeship Program will be expanded in 2024 to include a new occupational category - Frontline Supervisor - for apprenticeship. WSU will develop an additional series of online college courses ("badge" courses) for this new apprenticeship category.

We believe the issue of workforce shortages and development is one of the most critical to face our industry since its inception. As a direct Provider of care to members with IDD and other complex populations, ***Columbus*** (a CareSource affiliate with over 40 years of experience supporting DSP Providers across the country) is continually confronted with the issue of finding, developing, and retaining a qualified workforce to perform the work necessary to achieve optimal outcomes for our Members.

Columbus will help build capability with Kansas DSP through a comprehensive model of support. Columbus will develop a unique and broad range of strategies to identify, recruit, train, deploy, and manage potential DSPs. We will work with DSPs across Kansas to develop a targeted recruiting campaign for the clinical supervisors and DSPs needed to close gaps in Kansas. We have a dedicated recruiting team in our Professional Clinical Staffing division for hard to fill positions that we will deploy in Kansas. This includes job fairs, the use of online tools and databases, national conference attendance and direct calls. Columbus also utilizes our national candidate database, Jobvite, which is an end-to-end Talent Acquisition Suite that enables Columbus to attract, engage, hire, onboard, and promote the talent needed to best serve our Members.

Many DSPs struggle to hire, attract and retain quality DSPs. The best way out of the 'DSP turnover' cycle is to change culture. ***Blitz DSP Academy***, a CareSource Ventures affiliate, is an organization wholly dedicated to training DSP Providers to be world-class employers who attract and retain the right people for DSP roles. This is culture change, and Blitz DSP Academy does this through training and technical assistance to Kansas LTSS Providers through the Blitz DSP Magnet Academy which helps HCBS and behavioral health Providers attract and retain staff to support people with disabilities and complex health needs.

2. **CHWs:** Insights from our HealthAlliance Partners and our Kansas Provider subject matter experts, like Dr. Sandra Berg, helped us identify CHWs as a priority practitioner. The gaps that CHWs can help close in Kansas affect all areas, including rural and frontier areas of the State. We address our CHW expansion strategy for rural and frontier areas later in in this response.

   We first identify opportunities to leverage and support the full array of health professional and Provider types that are already present in communities. We also collaboratively assist in promoting the recruitment and retention of health care professionals and develop and share resources and tools that support health and health care professionals.

   We engage in existing mobile integrated care or community paramedicine programs, or support establishing one where none currently exist, along with deploying CHWs to identify needs and support connections. We also integrate peer workers to expand and encourage behavioral health access.

   We grow CHW engagement partnerships with key organizations in-market already doing this work (e.g., medical and nursing schools, CHW and peer advocates, etc.). We also utilize our nationally recognized workforce development program, CareSource JobConnect, to increase the number of quality candidates looking to become CHWs.

   We also expand CHW capacity in communities by supporting community colleges in creating and expanding CHW career pathways. We do this through scholarships and employment support after graduation. We also encourage partnerships and growth of CHW programs by sponsoring co-location programs through our Alliance partners.

3. **Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs):** Through analysis of state and industry data, as well as insights from expert partners, like Mission Care Collective, we identified CNAs and HHAs as priority practitioners for Kansas. Our solution to increase the number of CNAs and HHAs in Kansas is to utilize our CareNexus360 Center to support current Providers by increasing connectivity while leveraging our partnership with Mission Care Collective to both increase the number of candidates seeking a career as a CNA or HHA while also supporting their employers to take specific steps to retain and reward current staff.

4. **Mental Health Technicians (MHTs) to Support PRTFs:** Interviews and insights from our Alliance partners and Kansas subject matter experts, like Dr. Sandra Berg, also guided us to identify MHTs to support PRTFs as a priority practitioner for our Kansas strategy.

   We work with our HealthAlliance Partners and local colleges, like Butler Community College, to expand online and remote MHT-C training programs. Through JobConnect, we partner with workforce development boards to find and enroll eligible Kansans through these WIOA approved programs. We also provide scholarships through our HealthAlliance partners to help expand MHT-C coverage to areas with the highest needs.

Building a sustainable direct care workforce career path requires partnership and commitment. Our dedicated Employment Relations Specialist will work with colleges and workforce development programs across Kansas to develop career training paths for Kansans interested in a healthcare career. Additionally, we utilize WorkReady Koncepts, a state of Kansas contracted employment training vendor, to deploy mobile workforce training for our Members in rural areas who are interested in a direct care career.

5. **Attendant Care Workers for SED Waiver:** Insights from our subject matter experts in Kansas and a deep analysis of the non-traditional Provider network adequacy allowed us to identify Attendant Care Workers for SED waivers as a priority practitioner for our Kansas strategy.

   Kansas is facing a behavioral health workforce shortage. The future prosperity of Kansas depends on its ability to foster the health and wellbeing of people who go through emotional distress and their caregivers; this includes adults with diagnosable mental illness, and caregivers of children with SED and/or SUDs.

   Our approach to address gaps in Attendant Care Workers in Kansas engages local expert resources, like InterHab and the Children's Alliance, to build capacity, leverages expertise with our affiliate, Columbus, to build capability and draws on partnerships with organizations, like Mission Care Collective to build a culture that promotes retention of current workforce.

   CareSource supports workforce development for Attendant Care Workers, CHWs through initiatives such as our Community of Innovation and through partnerships with organizations like the Association of CMHCs and the Children's Alliance. In this groundbreaking Kansas partnership, CareSource supports CMHCs and the Children's Alliance in their efforts to increase capacity of Attendant Care Workers through professional recognition while simultaneously creating career paths including recruitment, training, retention, and advancement that allows for increased awareness and funding for this critical role. Much like InterHab's "DSP+" Registered Apprenticeship Program, which provides a national apprenticeship credential through the US Department of Labor, we are working with the ACMHCK and Children's Alliance to deploy a hub and spoke training program that supports Attendant Care Workers to enhance employability and upward career trajectory by providing training that focuses on supporting the needs of children on SED waivers, including diversion of unnecessary hospitalization or out of home placement, increasing the child's self-esteem and reducing natural support burnout.

   Columbus will help build capability with Kansas DSP Providers through a comprehensive model of support. Columbus has 40 years of experience providing clinical and case management expertise to Providers who engage Members in home-like settings. Leveraging this experience, Columbus will support all identified Providers utilizing Attendant Care Workers for SED waiver participants across Kansas with a comprehensive phased, sequenced learning management protocol that increases employee support and recognition.

   Blitz DSP Academy, a CareSource Ventures affiliate, is an organization wholly dedicated to training Providers to be world-class employers who attract and retain the right people for challenging direct care roles. Blitz will adapt its DSP Academy to help Providers employing Attendant Care Workers to build the necessary culture to attract and retain quality candidates in this role. Additionally, Blitz will assist Providers in effectively communicating with and supporting their Attendant Care Workers.

6. **Peer Support Specialists:** Data and advocacy groups focused on peer support gaps guided us to identify Peer Support Specialists as a priority practitioner for Kansas. We are committed to developing and growing Peer Support programs across the country. The need for these programs, especially in rural areas, led us to add PeerConnect to our industry-leading Life Services solution.

   PeerConnect is our multi-pronged strategy to increase the use of certified Peer Support Specialists to assist our complex health populations. PeerConnect increases Provider competency on Peer Support, Member awareness of Peer Support Services, Peer competency through training, Behavioral Health workforce, and access to Peer Support. We hire peer support staff internally and work with our CareSource JobConnect program to provide our Members an opportunity to become certified peer support staff and work within CareSource or other organizations. The goal for CareSource certified Peer Support Specialists is to manage a caseload of Members and transition those Members to an external peer supporter in their own community within 90 days. We will engage PeerConnect and JobConnect to find, develop, train and support peer supporters in communities throughout the state. Beyond our PeerConnect program we also support NAMI in their peer initiatives.

7. **Autism Providers:** CareSource recognized the lack of availability and access to timely care for children with an autism diagnosis through listening sessions with advocates across the state, particularly in the rural and frontier areas. As a member of the advisory committee for the KSKidsMap program, Dr, Sandra Berg participated in a collaborative to address the needs and processes in Kansas for meeting these gaps for Autism diagnosed children.

   CareSource's approach to supporting Members with autism includes early identification, advocacy, a whole person approach, and support for caregivers. One workforce cohort cannot meet all these needs, so an ecosystem of care has to be developed to align with keeping families supported through needed services. Screening is the first step and training pediatric care Providers on how to recognize and utilize EPSDT for early identification is critical. This is done through CareSource's collaboration with the KSKidsMap team to support the pediatric care Providers in identification and assessment of a child when they present for early identification as well as through our Project ECHO collaboratives. CareSource will work with StationMD to help identify and assess children early when local resources are not readily available. We also worked with Integrated Psychiatric Consultants to utilize their large Provider pool to help with the testing. Once a child is identified and diagnosed, the work of finding the right Providers begins.

   With the workforce shortages and delay in families receiving services, CareSource developed tools such as Augment Therapy, Virtual Reality, and Attend Behavior. Other caregiver solutions include providing training through OASIS program at the KU Development Center and through our proprietary application, Caregiving.com, which provides education, training, and parent peer support. We also look at how we can support the families in providing care by taking care of themselves through our Life Services program. We work with K-CART to support training new Providers of all autism direct services. CareSource will support K-CART to travel to different parts of the state and can provide scholarships for the Providers to participate in the training. K-CART provides competency training so ensure the Providers are meeting the standards set out by the state.

   We know that historically Kansas rates for autism services have been low and the state has made great strides in leveling the payment for these services. CareSource will work with Providers of autism services to enter into VBP agreements, supporting positive outcomes and supporting whole person support solutions. We partnered with several agencies within our HealthAlliance Partners to provide skills system training for their population with Autism Spectrum Disorder.

Rural and Frontier County Workforce Strategies

Each of the solutions below are operated virtually and are available across urban, rural, and frontier areas of Kansas and take particular care to identify local challenges in each of these regions to ensure solutions are tailored specifically to the needs of the community.

Mission Care Collective: To build capacity, CareSource partners with Mission Care Collective to provide coaching for people seeking a pathway in and upwards in health care, and alerts them to scholarships, resources, and opportunities to fuel growth within the industry. Mission Care Collective will identify CNA schools in the rural and frontier counties to receive two supportive services from CareSource. The first support service is access to a new Kansas CNA scholarship fund available to these rural and frontier CNA schools that meets award criteria. Second, in partnership with myCNAjob, each school will be equipped with a 3-year recruitment program. Through this collaboration, the schools are able to tap into the vast network of over 30,000 caregivers across Kansas. Approximately 55% of these caregivers have yet to acquire CNA certification and represent a diverse group of individuals: some who are already engaged in caregiving, others that may have left the industry for better paying jobs. With nearly 53% deriving from underserved populations and relying on public assistance. By employing strategic zip code-based recruitment strategies, we aim to efficiently populate CNA classes in the rural and frontier areas in Kansas.

In addition to partnering with Mission Care Collective, CareSource also collaborates with COF Training Services providing employment opportunities for individuals they serve through JobConnect. COF's vision is to provide lifelong support and services to individuals with IDD and together, we will work to help those achieve success in both their personal and professional lives.

Through our JobConnect program, the Employer Relations Specialist (ERS) is a key role. Their job is to identify and recruit employer partners to create a pipeline of CHW and Peer Support Specialists from our JobConnect program at no cost to the employer. The ERS will intentionally target those employers in rural and frontier counties to add to the curated list of partners and maintain a working relationship with their Human Resource department. This allows Members to have access to better paying jobs with potential advancement opportunities and provides employers with a candidate pool. The ERS will also collaborate with WIOA boards, KansasWorks, and hopefully be a part of the Kansas Training and Retention Aligned with Industry Need (KTRAIN).

[redacted]

Community of Innovation: The CareSource Community of Innovation is an innovative approach to improving Member outcomes by improving the experience of the Providers and stakeholders that serve them. All Provider types, community-based organizations, faith-based organizations, and other natural support systems are recruited and encouraged to participate in the Community of Innovation, building expertise and supporting integrated care across specialty systems. Through the development of a standardized approach to engaging Providers, assessing service needs/gaps, developing innovative solutions, and evaluating implemented outcomes, the Community of Innovation will produce quantitative and qualitive data that informs innovations and solutions specific to the needs of Kansans.

In demonstration of our commitment to this work, we officially launched the Community of Innovation in Kansas on February 6, 2024, with local Provider partners to identify and develop local solutions related to workforce and other systemic challenges impacting Member care. Members include GoodLife, COF Training Services Inc., WSU, and others. The Community of Innovation sessions are ongoing, and these local champions have identified specific workforce challenges, and are working together with CareSource, to build local and specific solutions that will be deployed and available to all Providers across Kansas, demonstrating that many of the best solutions are local solutions driven by those facing these very real challenges in their day-to-day efforts of supporting Members.

Project ECHO: Project ECHO CareSource is a component of the Community of Innovation and is an innovative telementoring model to help expand workforce expertise, capacity, retention, and subject matter expertise. Project ECHO was developed in New Mexico as a model to address chronic disease in a very rural and frontier setting. This model demonstrated wonderful success and has been in place for over 20 years addressing care delivery and knowledge gaps in rural and frontier settings by moving knowledge, not people. CareSource is approved by the University of New Mexico (UNM) as a Project ECHO Provider and CareSource is proud to be offering this program in true fidelity to the UNM, evidenced based model, of longitudinal clinics, which supports establishing and developing communities of practice and goes above and beyond webinars or content only educational opportunities. Project ECHO is informed by our existing network relationships with DSPs, CHWs, Tribal Liaisons, community Providers, and Patient Service Specialists. Additionally, all Provider types are actively recruited and encouraged to participate in Project ECHO to enhance their expertise, support improvement in clinical skills, improve integrated care, and increase staff satisfaction and retention. Providers that participate in Project ECHO CareSource are given free Continuing Medical Educations, Continuing Education Units, or Certificates of Attendance to continue to support their licensure and or continuing learning requirements. These can also be used to support non-licensed continuing education and career path educational goals. Participants in Project ECHO learn about trauma-informed, person-centered, recovery-focused care and the strategies to deliver services in a culturally aware and trauma-informed manner that has been demonstrated to increase employee satisfaction and retention, thus supporting workforce development in retention, access, and level of expertise.

Mobile Learning/Telehealth: We ensure Member access and ensure service delivery in rural and frontier areas through our virtual, telehealth network of Providers who specialize in chronic disease and LTSS. We work with StationMD to deliver telehealth services to members with IDD in their homes. Available 24/7/365, StationMD physicians complete more than 25,000 virtual encounters annually.

Q.4. Describe how you would identify HCBS service gaps to ensure authorized services are provided to members. How would you then address such gaps, particularly in areas of the state where self-direction may be the only option.

A.4.

Ensuring Authorized HCBS Services are Accessible to Members

Kansans across the state, but particularly in its rural areas, can find themselves on the outskirts of support, challenged to access essential HCBS services. Where others see an obstacle, **we see an opportunity to join forces with our Kansas community, who are already deeply engaged in this important work**. Our mission is clear: address these gaps and ensure every individual, especially in areas where self-direction stands as the sole option, receives the necessary services to support their well-being, independence, and ability to thrive. Restoring equity in care delivery is not just a goal; it's our imperative. To that end, our approach is highlighted below:

- CareSource has the technology in place to do **real-time gap analysis monitoring**, using multiple data sources, where historically this has been done retrospectively.

[redacted]

This gap identification and proactive outreach **support both** Members who are **self-directing** and those in **Provider-based** care.

We are bringing additional resources to Kansas to support individuals who choose self-directed care:

[redacted]

- Our **CareGiverConnect™** program to strengthen natural supports
- For Members choosing to self-direct, we are partnering with the **Consumer Direct Care Network** and other national partners to provide another level of support

Identifying HCBS Service Gaps

We proactively work with Members, Providers, and other stakeholders to identify HCBS service gaps and to understand barriers including network and workforce issues and devise strategies to bolster our capacity to serve Members. CareSource will work with KDHE, KDADS, the fiscal agent, and the EVV to ensure HCBS authorized services are provided to Members in a quality and timely manner and will use data from the EVV, Operations meetings, and the fiscal agent to monitor for HCBS compliance and to identify service gaps. Currently, MCOs look at EVV information retrospectively and CareSource is changing that by using our modern data platform to immediately match service authorizations and EVV with services performed in real-time. The Provider portal displays approved PAs immediately allowing the Provider to review and acknowledge. This platform provides automation to easily enter claim information directly from the waiver PCSP. Providers can send messages to the waiver Care Coordinator regarding changes or updates needed to the waiver PCSP to receive a quick response and support. EVV data sources are integrated into a real-time monitoring process that alerts CareNexus360 of late arrivals, triggering potential back-up plans to support Members.

Our CareSource HealthAlliance embodies many of the amazing HCBS Providers working in Kansas today. Additionally, we have consulted (and have Memorandum of Understandings with) KACIL and k4ad, and other advocates across the State regarding the needs of Members, including those who self-direct and those who live in rural and frontier areas where service access is a challenge. To ensure that services identified on the Member's approved PCSP are being provided, CareSource has a dedicated HCBS Oversight team to provide monitoring, education and training, technical assistance, and rapid response when HCBS services gaps are identified.

Our HCBS Oversight team has established trusted relationships with the CCCs and Targeted Case Managers who are closest to the Member. The community-based Providers have the greatest understanding of the service gaps and collectively, we collaborate and work to ensure that services are being identified and provided. We further equip and empower our HCBS Oversight team with tools that allow for **real-time identification of HCBS service gaps**, addressing Members' needs with speed and focus. Our HCBS Oversight team will formally collaborate with the CCCs in the following ways:

- **HRA and Health Needs Assessments:** Our HCBS Oversight team proactively addresses Member service gaps, informed through our HRA and health needs assessment (assesses personal care services). At each contact, or change in status, our Care Coordination team (in conjunction with the CCC or Targeted Case Manager) reviews the Member's HRA and health needs assessment for completed services, gaps in services, and changes in health or functioning. The HCBS Oversight team and our HealthAlliance Partners review these updates and assessments to assure timely quality services and continuous QI to address care gaps.

- **Coordination with the Financial Management Services (FMS) Coordinator:** Care Coordinators will work with the Member's FMS Coordinator and monitor for under or over-utilization of hours and budgets, as well as conduct reassessments if a change in allocation appears warranted.

- **Case Conferences:** Every HCBS Member is case managed and receives regular integrated case conferences. We conduct regular case conferences with community-based Providers to facilitate continuous communication and align resources, preventing duplication of care services and addressing gaps as needed. The case conferences are tailored to the Member's needs, and the Member can include key internal and external stakeholders. This integrated approach provides

ongoing monitoring and evaluation of the PCSP so that any barriers can be proactively identified and addressed, and services can be delivered in a timely manner. Any gaps are also identified and addressed. The case conferences are opportunities for providing advocacy, health coaching, education, and support based on the Member's preferences. The Member's assigned Care Coordinator organizes these conferences, involving representatives from both CareSource and external entities responsible for the Member's care coordination.

- **Joint Operating Committees (JOC)**: CareSource holds quarterly JOC meetings with contracted community-based Providers to identify, track, and remediate any policies, procedures, or other gaps that lead to access challenges or duplication of care coordination services. We will include our HealthAlliance Partners, KACIL, and k4ad in these meetings to support collaboration with Targeted Case Manager, CCC, OCK, and CCBHC Providers, as necessary. During JOC meetings, CareSource reviews the Responsible, Accountable, Consulted and Informed (RACI) matrix established in the Provider contract to ensure fidelity.

HCBS Gaps Dashboard:

Monitoring Network Adequacy
CareSource has the experience and expertise to rigorously address any network, time, or distance concerns and ensure access to quality care for HCBS. We are committed to working with KDADS, KDHE, Providers, the community, and other stakeholders to ensure a robust Provider network to meet all the HCBS needs for Members in Kansas.

CareSource understands that one of the root causes for gaps in care is availability of Providers and adequacy of the network. We continuously monitor network adequacy using our Optimization, Prioritization, Tracking, Intelligence, and other Contracting (OPTIC) Model for developing and maintaining a comprehensive network, which focuses on OPTIC methods. For service Providers with physical locations, we use monthly GeoAccess reporting through the Quest Analytics reporting suite to measure, monitor, and trend our network's performance and adequacy standards across all specialties statewide.

Addressing Systemic Gaps
We understand that many HCBS services gaps, particularly in rural and frontier areas, are long standing and chronic, needing creative solutions to address them. Our HealthAlliance Partners are active participants in various quality oversight committees to advise on the issues above, guide our programs, and ensure transparency and accountability to the State and our collective goals of holistic community care. Examples of such quality committees include: HCBS/LTSS Member Advisory Committee, HCBS/LTSS Provider Advisory Committee, Population Health Management Committee, Provider Advisory Council, Clinical Quality Outcomes Committee, and the Community Reinvestment Committee.

Ensuring Availability of Services Across Kansas
CareSource understands that it is our responsibility to address both the immediate service gap and to work towards addressing the systemic challenges that exist in accessing the full array of HCBS services.

[redacted]

Supporting Caregivers and Natural Supports
We recognize that the HCBS workforce shortage is a national challenge and requires a bold local approach. As part of our initial and ongoing PCSP process, the Care Coordinator/CCC/Targeted Case Manager facilitates and supports the Member to develop a comprehensive life plan which includes a back-up plan within the PCSP. The Member's backup plan lists alternative care sources (including both formal and informal support) and is updated at a minimum annually, quarterly, or when life circumstances change. When we identify a situation where an HCBS service gap exists, we immediately refer to the Member's back up plan. If appropriate, we identify and reach out to the Member's natural support. We take seriously our responsibility to identify, train, and support all caregivers, and we know this support is critical to helping reduce immediate gaps in service. Robust support is the core of our CaregiverConnect™ program.

Starting from the point of enrollment, we work with our Members to identify a network of natural supports in and around their community and help them get the training needed to safely assist our Members. We stay connected through our interactive, educational CaregiverConnect platform, powered by Caregiving.com, and provide access to a library of articles and short, skills-based training videos. We also partner with community-based organizations, faith-based organizations and local Certified CNAs and nursing training programs to recruit a broader network of support. In the event a Member's back-up plan does not include available staff or natural support, we immediately coordinate with Mission Care Collective to work with Kansas Providers and leverage a much larger float pool of qualified staff.

Bringing Additional HCBS Options to Kansas
CareSource is bringing multiple national partners to Kansas to address rural and frontier access. These solutions include:

- **Telehealth Solutions:** Our telehealth strategy includes an immediate and ongoing approach to services in rural and frontier communities, as well as expanding service hours to evenings and weekends in other more urban communities. Our strategy is multi focal. We ensure Member access and service delivery in rural and frontier areas through a contract with PURE, a virtual, telehealth network of Providers who specialize in chronic disease and LTSS. CareSource brings a specialty telehealth network to rural communities in Kansas and will cate or provide the tele platform to local Providers and to community-based organizations. We also work with StationMD to deliver telehealth

services to Members with IDD in their homes. Available 24/7, StationMD physicians complete more than 25,000 virtual encounters annually. Our telehealth strategy is community based in a Hub and Spoke Model where care is delivered by our specialty virtual Providers in a rural spoke, while any Member can be served by a non-virtual, local hub if for any reason local, non-virtual care is needed.

- **Self-Directed Care Support:** We partner with the Consumer Direct Care Network to help Members self-direct their care to reduce unmet needs, improve quality of life, and maintain positive health outcomes. This partnership offers an alternative to traditionally delivered and managed services by customizing HCBS to specifically meet each Member's goals, desires, and support needs. In-home services include budget management services; choice/co-employment services; self-directed personal care services; training and support for people self-directing care; support broker services; in-home caregiving services; respite services; chore services; habilitative care; vendor and product services; and veteran care services.

- **Columbus:** As a part of the CareSource family of companies and a nationally recognized leader in onsite and community-based professional staffing services, Columbus provides technical assistance and staffing solutions for Providers with workforce challenges. With more than 40 years of experience providing and maintaining professional clinical teams at state hospitals, developmental centers, community programs, and school districts nationwide, Columbus is expert in serving individuals with IDD and behavioral health needs. Columbus' professional team members have extensive expertise in clinical practice, recruiting professional staff, clinical research, staff training, community services, forensic issues, litigation issues, and developing policies and procedures for agencies servicing individuals with IDD. Columbus successfully provides licensed professionals (e.g., psychiatrists, Board Certified Behavior Analysts, speech language pathologists, occupational therapists, physical therapists) and other vitally needed disciplines to agencies who serve individuals with IDD and mental health disorders.

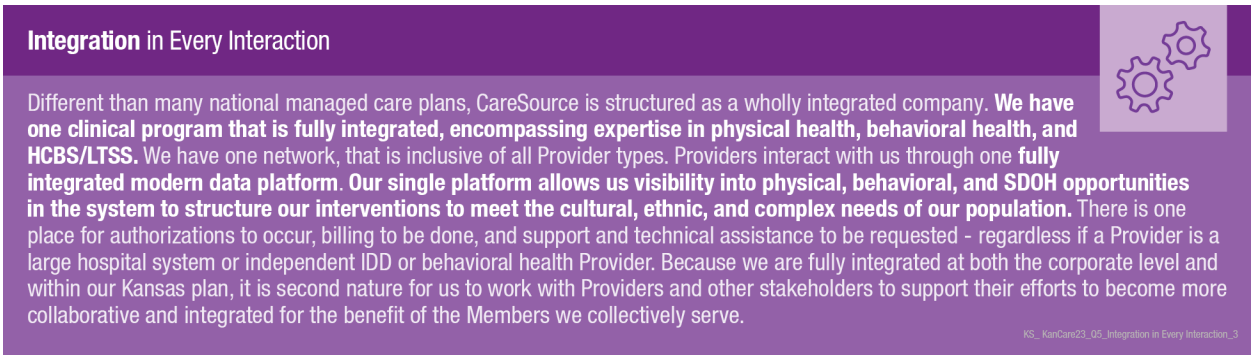
Q.5. Further describe the approach CareSource will utilize to advance integrated whole-person care. Specifically describe the role of incentives and value-based purchasing. How will your approaches address cultural, linguistic or health literacy needs? Finally, how will you know if your approaches are effective.

A.5.

Our Approach to Advancing Integrated Whole-Person Care

CareSource and our HealthAlliance Partners champion the importance of addressing the needs of the whole person and the impacts that physical, behavioral, and SDOH have on their journey to wellness. In fact, our HealthAlliance Partners already have focused integrated programs in Kansas such as the OCK Health Homes model, the CCBHC model, and cross-collaborative models within the system of care. Having behavioral health, IDD, and children- and family-focused Providers within the HealthAlliance enables us to uniquely understand the population needs and collaborate between systems. Further, CareSource has partnered with the Joint Commission on the CCBHC certification which focuses on whole person care and will offer training to our interested partners for specific CCBHC certification. Reaching certification will be a consideration for additional VBPs for Providers. CareSource's Project ECHO is an integrated care model and provides an opportunity for Providers to share experiences working with a diverse population and ways they can incorporate whole person care into their practices. We also partnered with NCQA on developing the PCOMs as part of our dedication to addressing all needs of all people.

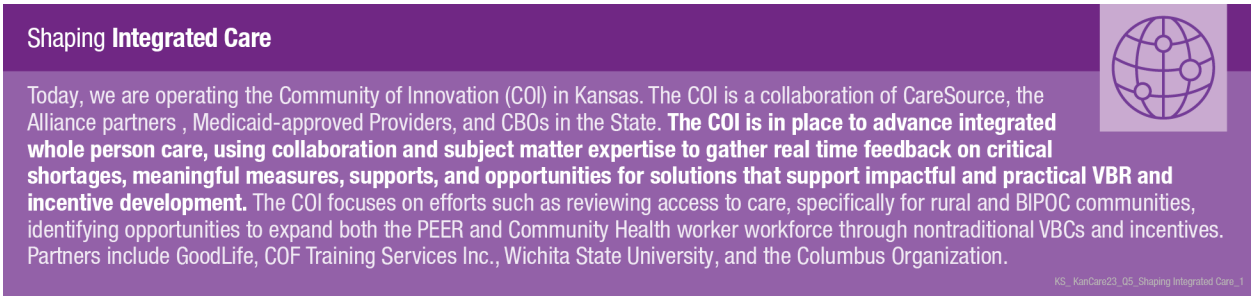
CareSource will incentivize Providers to shift their focus towards holistic 'whole person outcomes' beyond mere HEDIS scores. We understand that true transformation lies in VBP agreements, extending beyond traditional Providers to embrace the vital role of community-based organizations in effecting meaningful change in individuals' lives. By prioritizing incentives aligned with comprehensive care, we are committed to addressing cultural, linguistic, and health literacy needs, ensuring every individual receives personalized, culturally competent support. Our success is measured not just by metrics, but by tangible improvements in the lives of those we serve. Success will be further measured by work done with EQR partners to evidence cost effectiveness of programs, validate outcomes data, and show that quality assurance requirements are met for HCBS waivers.



The Guideposts for our VBP are rooted in providing integrated person- and family-centered services and supports to address health equity and disparities, ensure smooth transitions, and expand access to services by applying continuous QI. Drawing on our VBP experience and local expertise gained through our HealthAlliance Partners, we understand the positive impact that a well-designed incentive program has on Member health outcomes and on the SDOH that impact Member health and well-being. We also recognize that each Provider organization is at varying stages for a VBP. For example, InterHab VBP concepts include a spectrum of approaches for Providers at different levels of readiness. Feedback from

our HealthAlliance Partners informs us where they are prepared to focus efforts on VBPs and meet the State's goals.

We partner with Providers from the outset to assess their VBP capabilities and readiness, which results in their participation in the right fit VBP model. Consistent, reliable bidirectional data-sharing and communication enables the monitoring of performance and identification of Providers' readiness to move into more advanced VBP models. To support Providers, **CareSource pays a data integration fee to in-network community-based care coordination Providers to use** [redacted] for better collaboration on Member care and to avoid duplication of care coordination efforts. Additionally, CareSource offers Providers access to Project ECHO, an evidence-based program through which Providers across the State can earn continuing medical education credits, qualify for additional incentive payments, and learn best practices to improve all elements of their care delivery, including care coordination. Additionally, locally driven VBP model partnerships are derived from the Community of Innovation, including input from traditional, nontraditional, and HCBS Providers as well as community-based organizations.



Role of Incentives and VBPs in Advancing Whole Person Integrated Care

The CareSource Path to Value foundation aligns with the HCP-LAN APM Framework and HCP-LAN HEAT recommendations and supports the advancement of whole person integrated care by providing all Providers the opportunity to participate in programs ranging from simple pay-for-reporting and infrastructure payments to full-risk models. We have experience developing VBPs to align payment incentives with improved community access and enhanced LTSS Provider engagement in underserved areas. We also use VBPs to incentivize Providers to adopt workforce initiatives to strengthen evidence-based training, support, compensation, and career opportunities for direct care workers. Providers who meet benchmarks for workforce development and staff satisfaction receive incentive Payments.

We use VBP to incentivize our Providers for completion of Member health screenings and HRAs. We also use Provider VBP arrangements to incentivize Providers to assist us in getting Members to engage in their care. For example, in Georgia, our VBP arrangements resulted in a 23.7% increase in PCP visits. We also have shared savings models through which Providers can earn a percentage of realized savings.

Incentives and penalties are tied to medical loss ratio and quality performance targets. We continuously evaluate opportunities to grow our VBP models. In 2022, we developed a model that incentivizes mental health and SUD Providers for implementing a coordinated, comprehensive system of care for primary and specialty care, acute care and ED visit follow-up, and referral to community resources. Quality measures include, for example, medication management and initiation and engagement of SUD treatment. We increasingly enroll more Providers and align more Provider payments with VBP models. **Today, more than 80% of our network Providers nationwide are enrolled** in VBP arrangements. Additionally, 82% of Members are affiliated with a VBP-participating Provider.

[redacted]

CareSource VBP Example: Aligning to the Kansas Framework for VBP Arrangements
To advance whole person integrated care through our VBP, we worked with our HealthAlliance Partners, other strategic Providers, and community-based organizations to develop specialty VBP programs in addition to our standard VBP programs. These programs, described in the table below, make available higher reimbursement to Providers to increase their success at closing gaps in care and improving access and availability.

[redacted]

[redacted]

Provider Participation in Advanced VBP Models

We have deep experience engaging Providers in advanced VBP models. [redacted] There we implemented an innovative full-risk VBP model in collaboration with the Pediatric ACO Providers who represent all the Children's Hospitals across the State. Combined, this program impacts our 670,000 Ohio pediatric Members and links them with high quality local Providers. [redacted] We also have experience in Michigan, where we have a full-risk VBP model with Henry Ford Health that is delivering improvements in quality and utilization. Members served by Henry Ford Health had notable improvements in PCP and specialist visits, increasing 33% and 24% since 2021, respectively, as well as corresponding reductions in ED utilization and inpatient admissions. With respect to quality, from 2020 to 2022 for the HEDIS controlling high blood pressure and asthma medication ratio measures there was a 24.46% and 218.72% respective improvement.

Addressing Cultural, Linguistic, Health Literacy Needs

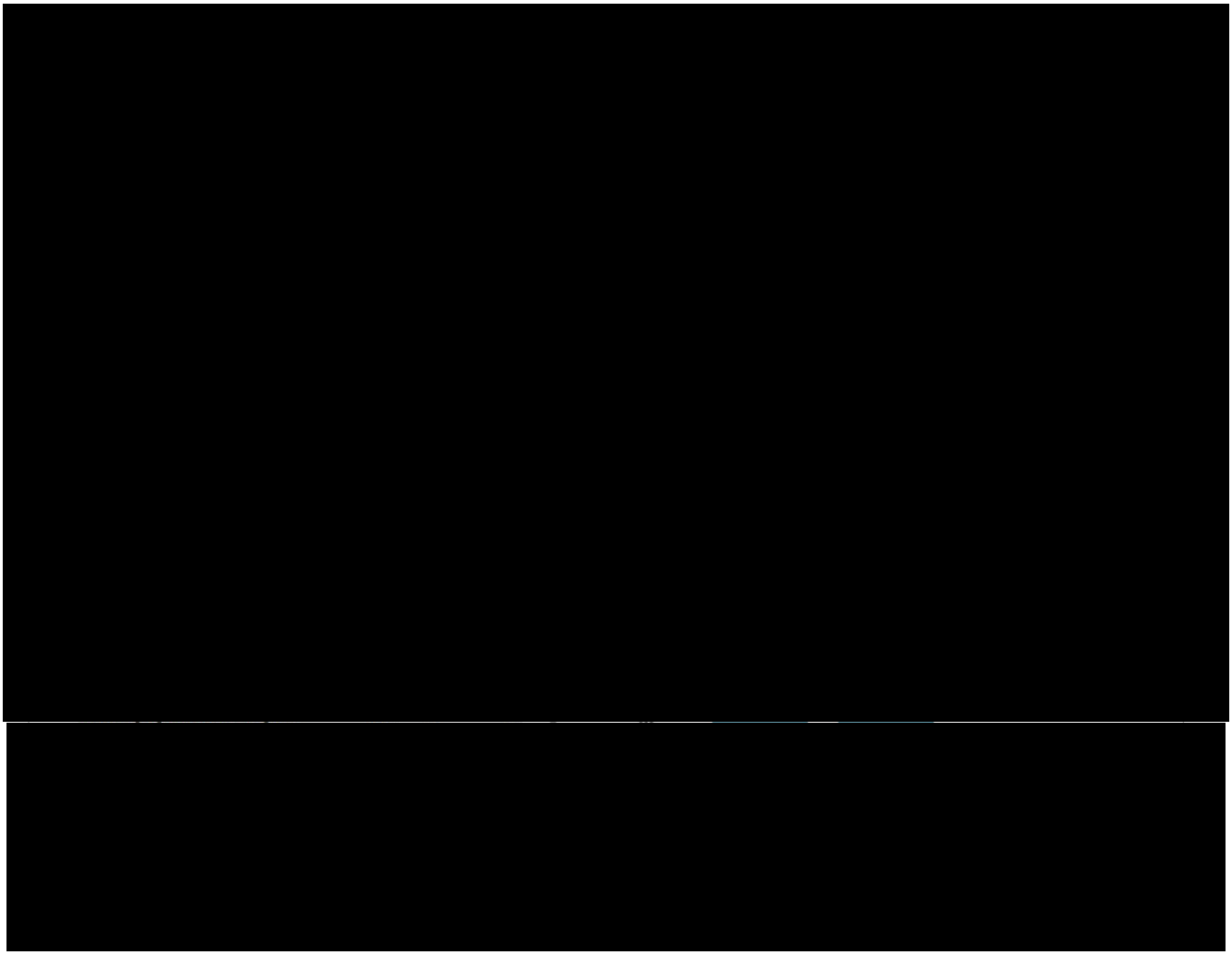
We have extensive experience incorporating equity considerations consistent with HCP-LAN's HEAT recommendations throughout our operations including VBP. All CareSource Medicaid plans are NCQA accredited and positive NCQA surveyor comments show our dedication to quality. We are also on track to obtain NCQA LTSS Distinction and Health Equity Accreditation/Health Equity Accreditation Plus. We have taken deliberate actions to address cultural, linguistic and health literacy needs as an organization on the whole and through our VBP program development. The following are actions we have taken to infuse health equity into our VBP approach:

- Adoption of CMS' health equity definition into our VBP Provider contracts, our Provider Manual, and all other Provider communication collateral
- Implementation of our Communities of Innovation to provide ongoing community-based and participatory engagement related to health equity
- Incorporate health equity into VBP program data that is shared with Providers and engage the Community of Innovation to design solutions to impact disparities identified through advanced VBP reporting
- Annually modify VBP measures to impact observed disparities through investment and supportive involvement

Our VBP program impacts SDOH by helping community-based organizations and Providers to connect Members with services including food banks, housing, and transportation. For example, in Michigan, we implemented a VBP incentive for Z code reporting. Using a NCQA-approved evidence-based collection tool, Providers screen Members for social care needs (e.g., education and literacy, employment issues, occupational exposures and risks, challenges with housing and finances). **The program has resulted in a 233% increase from baseline in Z code submissions.** Our VBP programs in Kansas are developed using approaches incorporating SDOH metrics and supported by our Life Services programs, where we will expect to see similar results.

Measuring Effectiveness in Advancing Whole-Person Care

Our Provider Network Management staff regularly meets with Providers to review dashboard reports and actionable data on specific quality measures, including Members with open and closed care gaps, incentive dollars earned, and incentive payment earning potential. Below are two examples of VBP dashboards and reports we have built for other markets.



To support Providers, we align Member programs and incentives. In 2023, for example, Members were rewarded for well-child visits and adult well visits, while Providers earned incentives if they met national benchmarks for well-child visits and adult well visits. Provider feedback is critical for increasing adoption of VBP arrangements. We engage Providers through our Provider Advisory Council, Provider satisfaction surveys, webinars, targeted outreach, our Provider portal, and monthly JOCs. These forums help us understand issues affecting Providers, identify barriers, solve care delivery challenges, share program information, and collaborate to improve data sharing.

We also measure our effectiveness in addressing cultural, linguistic, and health literacy needs by developing a plan for monitoring and addressing any unintended negative consequences. This includes closely engaging with Community of Innovation participants to understand lived experience and incorporate suggestions for change into VBP program design; implementing a standing agenda item focused on disparities at Provider Advisory Council meetings and JOCs; augmenting Provider training to

address feedback received regarding disparities and unintended negative outcomes of efforts; and encouraging, tracking, and considering Member feedback to inform VBP program design.
As previously detailed in our proposal response, we will establish a two-year pilot ADS VBP program to test whether directed investments and quality incentives can achieve the following system goals:

- Incentivize individual achievement of their unique goals/Member choice
- Improve readiness for community employment
- Improve individual functional skills
- Improve community integration
- Improve access to ADS among higher acuity individuals
- Improve Provider capacity/training
- Improve individual and family satisfaction with ADS services

The goal is to establish a scalable quality program incentivizing and facilitating improvements in specific quality measures, concentrating on individual outcomes for those in day services with complex needs. The pilot will involve a focus on pay for reporting and capacity building in the first year, with payments linked to reporting completeness. This includes funding for a QI Manager, staff training, and technology investments. The second-year shifts toward pay for outcomes, rewarding improvements in PCOMs based on initial measures.

Q.6. Describe ways in which you would reduce the administrative burden on providers and streamline processes with regard to utilization management. What processes do you have in place to assure that providers will have a true peer (i.e. same specialty) when appealing a decision?

A.6.

CareSource is committed to continuing the reduction of our UM PA requirements by 20% in 2024 so we can better support and reduce Provider administrative burden. Over the past three years we've done an extensive review of all our PA requirements, and **we have reduced our PA requirements by more than 1,500 service codes.**

The heart of our success is our decades of experience as a trusted partner to Providers and our unique HealthAlliance perspective which allows us to understand what matters to Providers most. Our unparalleled operational excellence encourages Provider participation by decreasing administrative burden, with a focus on transparency. **This level of collaboration and transparency has led to Providers reporting high levels of satisfaction.**

We invest in automation and technology to reduce administrative burden and support efficient and timely authorization responses. Our 2023 Enterprise TAT compliance reflects the Providers' ability to obtain authorizations promptly and support timely access to care for Members.

2023 TAT Compliance	Percentage
Non-urgent	**99%**
Urgent	**98%**
Standard prior auth	**99%**
Concurrent	**98%**
Retrospective	**100%**

Methods to Reduce Administrative Burden and Streamline UM Processes

We are committed to reducing Provider burden through:

- Providing real-time decisions via Cite AutoAuth
- Automating authorization, concurrent review, and communication exchange via collaborative care
- HCBS Provider input
- Provider sourcing tool
- Population Health Focused PA Model
- VBP models focused on reducing PA
- Provider Advisory Council
- Enhancing Provider authorization status (Gold Carding)

Over 73% of PAs are submitted via the portal today, with nearly half of those receiving immediate decisions without further medical review. We always welcome Provider feedback within the designated Provider portal and have supports in place to help guide Providers while monitoring the portal for ease of use, resulting in increased electronic submissions.

Cite AutoAuth

Online portal requests have access to Cite AutoAuth within the authorization request. This application enables real-time communication between CareSource, Providers, and Members. This application is integrated with MCG Care Guidelines evidence-based criteria and offers the user the ability to complete a guideline review using Member specific clinical information directly from the team caring for the Member. If the user elects to use the application and provides the clinical information supporting medical necessity

criteria, they can receive a real time approval. If medical necessity is not evident via Cite AutoAuth, the PA will transition to the Clinical team for review. This approach translates to our Providers ability to receive immediate approval to implement the PCSP resulting in Members receiving care without waiting for an authorization.

Collaborative Care

CareSource became one of the first adopters of MCG Cite for Collaborative Care, a platform that uses interoperability technology to connect payers and Providers via our respective medical management and EHR platforms. Through this integration, **the Provider can select pertinent clinical information to share electronically, support medical necessity using MCG with only a few clicks, and in some cases receive an immediate approval.** If the authorization does not receive an immediate approval, it is reviewed by the clinical team. When complete, the decision is communicated directly back to hospital EHR. This process enables both the payer and Provider to avoid the tedious fax communication process (reducing incoming faxes by 60%) and allows data interaction to happen in near real time. When implemented, this engagement results in reduced administrative burden for the hospital and a reported savings of 20 hours per week in the authorization process. Collaborative Care is integrated with multiple EHRs such as Cerner, Meditech, and EPIC.

HCBS and Child Welfare Provider Input

CareSource leverages HCBS Provider input to design and integrate the PCSP into Provider portal to streamline access for the HCBS Providers to sign/acknowledge PCSP, submit completed services that will audit generate a claim - the Provider can also view status of claim and receive near real time payment for certain criteria (rural and frontier Providers). This integration provides a user-friendly platform for the Provider to acknowledge/sign waiver services, enter services performed and automatically submit claim streamlining the process for HCBS Providers to ensure timely payments for services rendered. Our modern data platform immediately matches services authorization and EVV with services performed. The Provider portal displays approved PAs immediately allowing the Provider to review and acknowledge. This platform provides automation to easily enter claim information directly from the waiver PCSP. Providers can send messages to the waiver care manager regarding changes or updates needed to the waiver PCSP to receive a quick response and support.

Further, from our partnership with the Children's Alliance of Kansas, we have identified a key benefit of working collaboratively and regularly between child welfare advocates and programs which is that we can identify barriers through practical experience of child welfare Providers where current UM practices are negatively impacting timeliness of services. Together we identify barriers to health care access for children in foster care and develop targeted processes to leverage the child welfare case management Provider network to support removing UM barriers for children in foster care in ways that might not otherwise be available to other populations without a similar network of case management coordination. Child welfare Providers support CareSource by identifying PA barriers unique to this population and collaboratively develop procedures to remove delays in care. Furthermore, we welcome the opportunity to lead collaboration with other MCOs to remove barriers for children involved in the foster care system.

Provider Sourcing Tool

Implementation of a Provider Sourcing Tool helps to decrease multiple contacts to Providers when services or home modification is needed. This tool posts Member needs in a PHI protected format with specific information that allows all Providers to respond if they can to provide HCBS services and/or submit their bid for work home modifications, and plan logistics to ease Provider burden in locating resources and increases access for our Members.

Sample Images from the Provider Sourcing Tool

Population Health Focused PA Model

Our PA strategy is structed to ensure Members have timely access to care for clinically appropriate services, allowing Providers to obtain authorizations for adjunctive services with one authorization. This PA model ensures timely access to clinically appropriate, quality care. Our commitment and process on reduction of PA is provided through analytics, monitoring trends and governance structure, which all decrease the burden and support early access to care.

VBPs to Reduce PA
For high-performing Providers, we may offer additional relief from Provider burden by offering our VBP option, which enables these Providers to bypass our standard outpatient PA process for qualifying services.

Provider Advisory Council
Our Provider Advisory Council meets quarterly to discuss challenges our Providers face, including administrative and operational barriers, and works collaboratively toward resolution. We also receive feedback on referral gaps and gain insight regarding what works well for Providers and where they wish to see process improvements or additional support from us.

Enhancing Provider Authorization Status (Gold Carding)
We may identify a Provider who has a good track record of appropriate utilization, continually delivers quality and cost-efficient care and demonstrates above average consistency in authorization approvals and adequate volume of PA requests. When this occurs, we may identify the potential for gold card status for the Provider. Once a Provider is gold carded, the PA process is eliminated, and we will monitor the Provider's performance going forward to ensure ongoing quality. Though our oversight process, we review monthly performance metrics to ensure performance remains consistent and gold carding is successful. Any concerns are addressed through a collaborative partnership approach with the goal being to improve success and prevent reinstatement of the PA requirement. **We are committed to a refined PA experience for Kansas Providers ensuring PA requirements drive quality of care and minimize administrative burden for Providers.**

Ensuring Same Specialty Peer Review
We know the importance of same specialty peer reviews and our model ensures peers, with the same expertise and experience as the providing Medical Director, evaluate the most current clinical information available. If a peer review is needed during the clinical appeals process, the nurse will refer the case for review, making certain the same specialty Provider completes the review. We have more than 25 specialty Providers on staff and a full suite of Providers from every specialty at our disposal that assist in UM reviews. This includes essential behavioral health expertise such as addiction medicine, child psychiatry, and behavioral analysis. These specialty-specific Providers review claims within their field to help expedite PAs and ensure services are reviewed and facilitated correctly. For example, we have an internal team of NICU specialists available to review NICU cases, as well as other specialists who are experts in their designated field of radiology, oncology, and cardiology, just to name a few.

Commitment to Kansas
Our Member-centric, evidence-based UM model ensures Kansans receive appropriate, timely, and cost-effective medical, behavioral health, and LTSS across the care continuum to optimize health outcomes and improve the Member and Provider experience. The program we use to manage utilization of covered services is further enhanced by our NCQA-certified UM process, innovative programs, and sophisticated technology resources that we use to oversee utilization for 2.1 million Medicaid Members nationally. We will ensure our MCG certified UM staff are adhering to regulatory, CMS, NCQA, and clinical services processes and operations.

Our UM Program is purposely built to effectively ensure quality access to care for Members while simultaneously reducing Provider administrative burden and the ability to meet State requirements. We are committed to driving efficiency and innovation in PA management; therefore, we will continue to streamline our business processes and promote transparency and ongoing information sharing so Providers can focus on Member care.

Q.7. How will you ensure compliance with access and service standards for Non-Emergency Medical Transportation? How will all members be aware of how to access such transportation, including urgent needs? How will you measure effectiveness of this service?

A.7.

Kansas Members benefit from CareSource's partnership, collaboration, and disciplined oversight processes developed over time for NEMT services. Our NEMT solution brings an exceptional level of knowledge and experience to address health equity, challenging geographic areas, SDOH, and Members with unique needs. We collaborate with [redacted] This will ensure CareSource NEMT services exceed the standards set forth in the RFP.

Ensuring Compliance with Access and Service Standards for NEMT

The CareSource partnership combines many decades of thoughtful leadership to provide a seamless transportation experience for Kansans. Our experience coordinates and ensures timely and reliable provision of NEMT, transporting Medicaid populations with various abilities, including Aged, Blind, and Disabled, Members with IDD, or those receiving LTSS. CareSource's dedicated Member Transportation Experience team deploys a robust Member experience management and oversight program focused on ease of coordination of Members' timely, reliable transportation.

Ensuring Access

To develop, maintain, and oversee our high-quality NEMT Provider network, we continually assess network quality and adjust as necessary to serve the needs of our Members. [redacted]

Innovation: Peer Transportation Initiative

In addition to the robust benefits CareSource plans to offer [redacted], we are engaged with the Johnson County Mental Health Center (JCMHC) to expand implementation of their peer-supported transportation program to benefit our membership. CareSource will enact similar programs, in collaboration with JCMHC's existing model and mentorship, to expand this Member-focused transportation solution into two additional urban areas and one rural setting.

[redacted]

[redacted]

Ensuring Member Awareness and Understanding of Using the NEMT Benefit

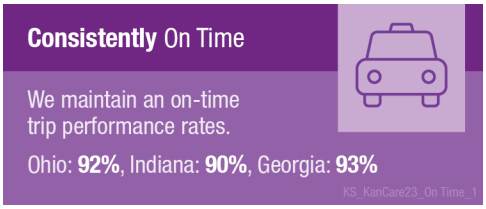
We ensure Member awareness through several Member touch points and through widely distributed and readily available Member information. Initially, new Members will receive a welcome call to understand their benefits, followed by a phone call from a Care Coordinator to review the Member's needs and create a PCSP. Members receive detailed information and instructions on NEMT services in the Member Handbook upon enrollment as well as the NEMT phone number on the Member identification card in compliance with RFP requirements.

Members are given instructions on how to access transportation, how to use it, and how to obtain reimbursement. This includes how to schedule trips for urgent needs that fall outside of typical protocols. Our Member newsletters, distributed quarterly, furnish refresher information and any news about added features within the NEMT program. CareSource also works with Providers to offer training to key staff on the types of transportation benefits available to Members, enabling the Provider to recommend using NEMT when the need arises. In addition, we continually leverage community-based organizations to help share the information. The NEMT guidelines are on our website, and our Member Services call center is equipped to expertly answer questions about NEMT [redacted]

Providing Urgent and Rapid Response Trips

We know not all health care needs can be planned in advance. That is why we do not place limits on Members' urgent trips. We arrange for pickup within three hours from when the urgent request is made. To confirm these trips are fulfilled on time, we require Members to request urgent trips by calling the Member Services toll-free number and [redacted] In addition, Members can use self-serve options, such as web chat, the Member portal, or the mobile app.

When a Member requests an urgent trip, [redacted] verifies the urgency of the appointment with the medical Provider by phone. Once the appointment is verified as urgent, they proceed with scheduling transportation. If the trip request is determined not to be urgent, they will educate the Member of the standard NEMT benefit. The Dispatch and Logistics teams work to place short-notice, after-hours, and urgent trips with available transportation Providers. They call transportation Providers who cover the service area to determine availability, confirm the trip details with the Provider and the Member or representative, and negotiate rates for the trip if necessary. If [redacted] dispatches a trip to a transportation Provider less than 48 hours in advance, they contact that Provider by phone to confirm they can accommodate the trip or send the trip directly to a driver for acceptance.



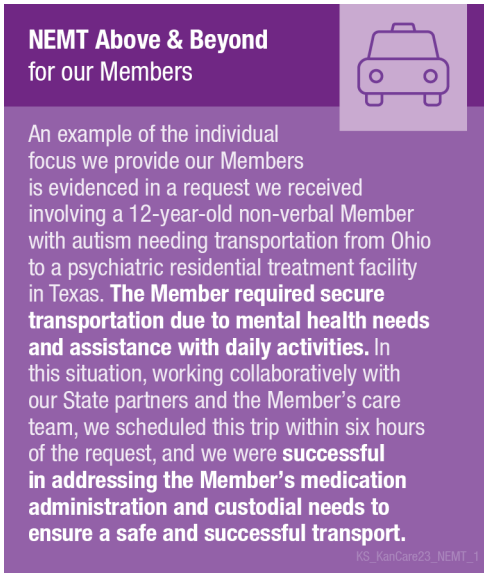
For rapid response trips, when a driver is running behind, the platform generates a notification so trips can be reassigned to an alternate driver or Provider in the area if necessary. During training, logistics staff also educate transportation Providers to notify [redacted] immediately in the event of any problem that might cause a trip delay. Immediately after notification, [redacted] contacts the Member and the facility or individual at the destination point and documents the notification. Once an alternate Provider is located and accepts the trip, we notify all appropriate parties of trip changes via phone call, text message, and email.

[redacted]

Measuring Effectiveness of the CareSource NEMT Benefit

CareSource [redacted] use data-driven sources to execute program improvements. Our teams continuously review data such as mileage, trip modality, trip type (recurring, multiple destinations, or on-demand), and trip reason to determine which data points may be driving correlations to missed trips, no-shows, or complaints. For example, trips involving ambulance, stretcher, or paralift modes; dialysis; or high mileage typically result in the highest rates of complaints and no-shows. Targeted solutions to improve the Member experience involve engaging transportation Providers with ambulance, stretcher, or paralift capabilities for added services and training, and using a risk evaluation scale for long distance trips to identify and solve for failure points that are a risk to the trips' success.

Additionally, under CareSource's leadership, [redacted]



Meeting Service Standards

Our Member Transportation Experience team's sole purpose is to ensure a best-in-class NEMT experience for Members. The team monitors both compliance and service standards through proactive oversight. We monitor and trend a core set of critical success factors on a daily, weekly, and monthly

basis such as trip log data (pick up and drop off times, trip leg evaluation), Member Services call inquiries, grievance information, Care Manager feedback, and leg-by-leg and enroute monitoring of unique needs trips. This proactive approach and daily engagement ensure timely and dependable access to care while ensuring continuous improvement based on Member insights and feedback.

[redacted]

Our Member Transportation Experience team participates in Member Advisory Committees to help shape benefits, policies, and procedures. For example, in Ohio, where we provide a similar set of covered services as those required in Kansas to an average of 1.4 million Members since 1989, we identified a growing need for secure transportation as requests increased by over 200% from Q1 to Q2 2023. We proactively worked with [redacted] to increase the number of transportation Providers and vehicles capable of meeting this need. As a result, we effectively scaled our transportation network to meet the eventual four-time demand increase for these types of trips.

In 2021, our Member Transportation Experience team identified a specific transportation need that involved Members requiring transportation support to attend SUD treatment appointments. Transportation requests for SUD rides were increasing exponentially, and because of this identified need our Member Transportation Experience team recommended updating our transportation benefit to allow for unlimited critical care trips during the second half of 2021. Through this change, Member SUD trips continued to increase in 2022 by over 219%, and by an additional 55% in 2023. Our Member Transportation Experience team worked with our vendor to develop their network in such a way that they were able to manage this increase in volume while maintaining a 99.89% complaint free ride percentage. Through our Member Transportation Experience team's ongoing engagement with our vendor and our transportation data, they were able to align our benefits to better meet the identified needs of our Member population.

Our Vendor Oversight team provides another layer of formal contract compliance [redacted] Our team proactively audits more than 16 service level agreements to which we [redacted]. This ensures compliance with all contract and mandated requirements. The service level agreements include substantiated complaints and grievances (must be less than 1% of total rides), on time arrival (must meet 95% on-time arrivals for pickups), and no-show percentage (must meet less than 0.75%). This team issues CAPs if there is a failure to comply with agreed-upon metrics and service levels to quickly address the gap in service that caused the non-compliance. The Vendor Oversight team also enforces a financial penalty with contracted vendors should there be failures to comply with service standards.

Q.8. Provide specific details on your recruitment and contracting strategies to develop a provider network. How is that process different for varying provider types? Describe the current status of your network, including the current numbers and letters of intent by provider type.

A.8.

All Kansans deserve access to high-quality Providers who can meet their unique health needs, *wherever they live.* Our personal approach to developing an adequate, qualified Provider network is built on our decades of experience as a trusted partner to Providers and our unique HealthAlliance perspective.

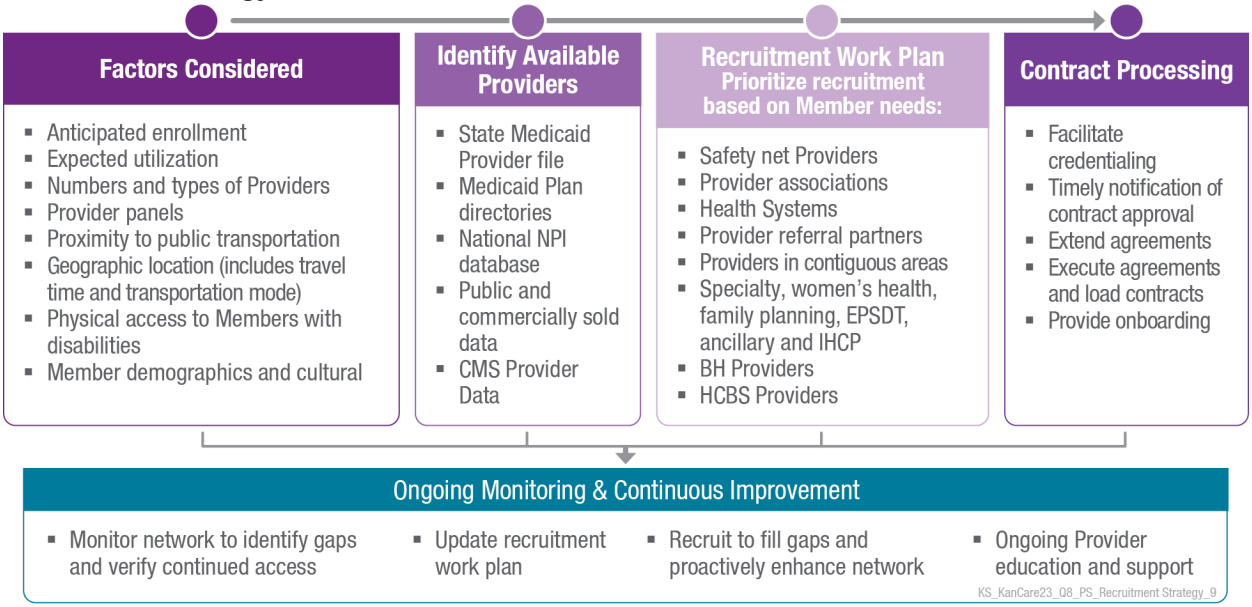
[redacted]

For the past three years, we have been actively immersed in Kansas, building relationships with Providers one-on-one so we can understand their unique experiences firsthand. While our contracting efforts are still ongoing, [redacted] These efforts have well-positioned CareSource to **exceed adequacy standards** in advance of go-live.

CareSource Provider Network Recruitment and Contracting Strategies

The foundation of our strategy is to identify and prioritize the contracting of available Providers by overlaying time, distance, and covered services requirements with Member location and network needs.

Recruitment Strategy



Network Needs Analysis
Provider recruitment activities begin with the identification of all qualified Kansas Medicaid Providers through analysis of State Medicaid Provider files, Quest GeoAccess data, current Medicaid Plan directories, the NPI Database, and public and commercially available data. We evaluate this data for the following:

Data Point	Description
Anticipated enrollment	We project potential changes in membership quarterly and use the information to evaluate network needs and adjust to our recruitment strategy. We consider Provider count and need for specific Providers.
Expected utilization of services	We identify our Members' health care needs quarterly and evaluate the network to identify need for additional Provider recruitment.
Number and types of Providers	We generate monthly reports using Provider types from State guidelines, HEDIS requirements, and Member needs, including an assessment of Provider capacity.
Panel status and Providers not accepting new Members	We review the panel status of our PCPs by county and region quarterly and use this data to identify access barriers and implement additional targeted recruitment efforts. Upon identification of a closed panel, we review network PCPs in the same geographic area to ensure there are sufficient PCPs with open panels to provide appropriate access. We regularly monitor our network to confirm willingness to accept our Members.
Proximity to public transportation	Each quarter, we collect information about Provider proximity to public transportation. We use this information to identify recruitment opportunities and assist Members in selecting a Provider that is accessible via public transportation. If unable to use public transportation, we offer other solutions such as our NEMT vendor.
Member-to-Provider ratios	We incorporate Member-to-Provider ratios monthly to validate adequate Member access and Provider availability. We use results to target geographic areas and/or specialty types in need of recruitment and pursue contracts with those Providers.

Recruitment and Contracting
Our recruitment strategy entails connecting and engaging Kansas Providers located in the areas where our Members live. We prioritize the contracting of available Providers by overlaying time, distance, and covered services requirements with Member location and network needs. We contract with any willing Provider who wishes to be in our network and can meet our commitments to quality, cost, outcomes, and credentialing standards. Our locally based teams engage with Providers to secure contracts and initiate the credentialing process. As we contract each new Provider, we take steps to streamline and reduce any administrative burden associated with the contracting Provider.

Monitoring
CareSource demonstrates and continuously monitors network adequacy, in accordance with 42 CFR 438.206 and State requirements to ensure we maintain an accessible network in all geographic areas, across all Provider types, and in compliance with time, distance, and appointment time standards. We evaluate network development progress weekly using Quest GeoAccess and prioritize our contracting efforts based on time, distance, and covered services requirements. In addition, we leverage Trilliant competitor claims data to ensure that we are contracting with Providers that provide care to KanCare recipients. This technology assists in ensuring we combat against 'ghost network' issues experienced by many Medicaid managed care programs.

Network Accessibility Monitoring Activities

Monitoring Activities	Description
Secret Shopper Calls	**Reviewed Quarterly:** Secret shopper calls to assess PCP and specialist Provider compliance with availability requirements; surveys include 25% of the network every quarter or 100% annually; Providers who fail are put on a CAP and are reassessed again before the end of the year
After-Hours Calls	**Survey Conducted Annually:** After-hours survey via a vendor to confirm the availability of PCPs (or their designees) to Members after normal office hours
Utilization Analysis	**Reviewed Monthly:** Use of ED and urgent care services can be an indication that the Member could not secure a timely appointment. We analyze overall trends and trends specific to non-emergency and non-urgent billing codes
Use of Out-of-Network (OON) Providers	**Reviewed Monthly:** Analysis of OON single case agreement requests can be an indication of unavailable appointments
Inquiries, Complaints, Grievances, Appeals	**Reviewed Monthly:** ▪ Provider inquiries looking for assistance with scheduling a Provider appointment for a Member referral ▪ Member inquiries requesting assistance scheduling an appointment ▪ CareSource24® nurse advice/ behavioral health line call volume and type when a Member indicates they were unable to schedule an appointment ▪ Inquiries by Members looking for appointments related to their PCSP

Different Recruitment and Contracting Strategies Based on Provider Type

CareSource's recruitment strategy is more than just meeting adequacy standards. Our engagement is personal and our solutions for Providers is personal. Our recruitment strategy addresses the needs of all Providers in our network, with an understanding of the unique capabilities and capacity of varying Provider types.

This approach is based on the principals of effective communication, easy access to information and resources, and active representation and advocacy. Our local Provider Relations team has specialized expertise and experience in contracting with varying types of Providers. They utilize one-on-one in-person and virtual meetings with Providers to address needs and to work through how each Provider can be successful. We also customize our agreements, VBP programs, dashboards and meetings around the Provider, their practice, feedback and needs.

We have also expanded our definition of "Provider" to create strong alignment among all stakeholders that support our Members. Our Community of Innovation brings together Providers, including HCBS Providers, community-based organizations, advocacy groups, individuals with lived experience, and other stakeholders to the table as collaborative partners to identify problems, develop solutions, and make decisions, ensuring their voices and expertise are valued. This model develops innovative solutions to improve the Member and Provider experience, reduce service and product gaps and barriers, and strengthen industry partnerships."

HCBS Provider Approach

HCBS Providers require the most unique approach we employ to recruitment and contracting. We believe that to establish a strong HCBS Provider network, we must, and we have developed partnerships dedicated to the integrated care delivery. Our approach includes an intentional re-design of our Provider

contracting tools to effectively partner with HCBS Providers. We streamlined our Provider contract specifically for HCBS Providers to accommodate their differentiation. By abbreviating the contract, we reduced it from 17 to 8 pages and removed clauses and requirements that are not applicable to HCBS Providers, resulting in greater ease of contracting with us. This approach refined the contracting strategy to make it applicable specifically to the types of services delivered by HCBS Providers and accounts for how these Providers are identified, referred, and licensed/credentialed. As a result, HCBS Provider expectations are more clearly defined and more applicable to the specific populations they support.

Physician and Hospital Approach
We attract and retain our network of high-quality physicians and hospitals because we make it administratively easy for Providers to work with us and our Members do not need a referral to see these in-network Providers. However, if there is a reason a Member would benefit from seeing an out-of-network Provider, or in the event there is not a network Provider available within the access standards, we work with the Member and their care team to ensure access to specialty services using single case agreements.

Behavioral Health Approach
CareSource recognizes the importance of a high-quality and accessible network to serve our Members with behavioral health needs. As we noted in our response above to Q.3., we recognize the critical shortage of behavioral health Providers and the consequences that it has for all Kansans. It is a driving objective in assembling our HealthAlliance Partners, many whose member organizations are foundational to attaining network adequacy. Rather than taking a cookie-cutter approach to value-based contracting with behavioral health Providers, we have been exploring VBP arrangements that are tailored to their needs and complexities.

Dental and Vision Approach
We subcontract for dental and vision services and incorporate network development activities for subcontractors into our recruitment strategy. Our relationships with our subcontractors are based on delegated service agreements. This framework ensures we have a written agreement with all entities with whom we subcontract that defines subcontractor activities, reporting, and penalties if the subcontractor does not meet the contract requirements. Through our established oversight structure, we monitor subcontractor network development activities and ensure compliance with all requirements that are in our contract with KDHE.

Current Status of KanCare Network

[redacted]

Current Status of Commitment by Provider Type

[redacted]

[redacted]

CareSource has developed a comprehensive network of Providers with the capacity and expertise to partner with us in the delivery of whole person integrated care to our Members. While we have made good progress in growing our network, there were some providers who would not contract in advance of the award announcement. For those Providers not yet contracted, they stated they would continue to work towards a contract but could not accommodate a timeframe to finalize before our submission date.

We will continue our recruitment activities to overcome barriers to contracting and establish the most robust provider network possible for KanCare Members. Our network foundation is strong and will fully meet the needs of the KanCare population for go-live.

> We have had numerous brainstorming sessions with CareSource to work through how they can invest back in Kansas communities in a way that is meaningful to Members across Kansas. This means conversations about how to assist with services for those on the HCBS waitlist as well as how to support the gap in services on the Physical Disability, Brain Injury, and Frail/Elderly waivers from losing case management services. CareSource is invested in looking at these problems from a new perspective and exploring options to use value-add and in-lieu of service strategies.
>
> **Kansas Association of Centers for Independent Living**

KS_KanCare23_Q8_KS Assoc of Centers for Independent Living Quote_1

The diligent, on the groundwork in Kansas connecting with and meeting with Providers contributes to a strong and secure network for our Members. [redacted] Further, we have a firm understanding, from hospitals and Provider groups who have not yet signed a LOI, that they will participate in our networks upon award.

Providers Chose CareSource

Providers want to work with us as evidenced by our achievement of Net Promotor Scores of **>80%** for the likelihood that Providers would recommend CareSource to other Providers. Our operational excellence emphasizes Provider simplification with an unparalleled **99%** of claims paid in five days and a first call resolution rate of over **93%**. **Our goal is to make it easy for Providers to focus on the most important thing- Member care.**

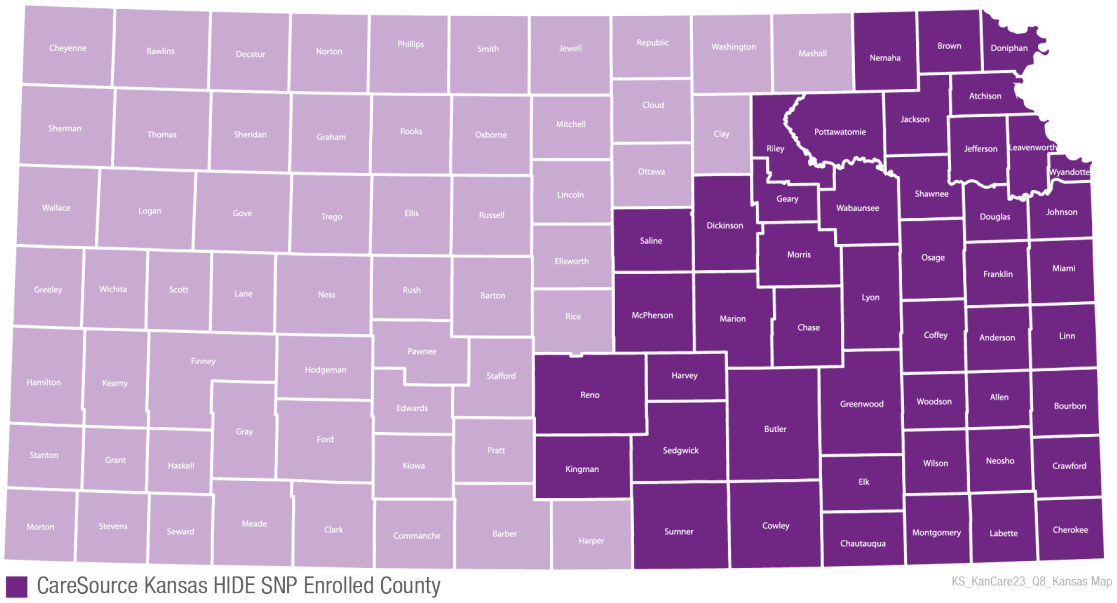
KS_KanCare23_Q8_Providers Chose CareSource_1

Current Highly Integrated D-SNP (HIDE SNP) Network

CareSource understands and is committed to Kansans served under a Highly Integrated D-SNP (HIDE SNP). We acknowledge that persons eligible for Medicaid and Medicare (dual eligibles) are among the nation's most vulnerable individuals because of their multiple chronic conditions and correspondingly complex health care needs. Currently, these individuals face the daunting challenge of accessing two separate health care systems which often lack effective communication and care coordination, resulting in difficult system navigation and unsynchronized costly care. As such, CareSource created our Model of Care (MOC) application (H Contract #1569) and a detailed Provider network to support our Kansas HIDE SNP and filed that application with CMS on February 14, 2024. CareSource is on track to offer a HIDE

SNP plan to KanCare dually eligible Members in 47 counties in North-East and South-East Kansas, as illustrated in the map below.

CareSource Kansas HIDE SNP Service Area (per CMS Application/Filing in February 2024)



CareSource has experience operating and managing programs and plans for dually eligible Members. We create better outcomes for our Members by providing a centralized point of contact between programs and streamlining a comprehensive network of Providers, community agencies, and other services and supports that are diverse enough to meet the dual eligible population's specialized needs. As part of a concentrated, focused effort since release of the KanCare RFP, CareSource has made considerable progress in building our Provider network to support the HIDE SNP on January 1, 2025. In our 47-county service area, CareSource is currently **95% adequate** pursuant to CMS' adequacy standards utilizing both fully executed agreements and CMS compliant letters of agreement. We will continue to build and expand this network following award to offer a competitive and attractive HIDE SNP program to some Kansas most vulnerable population.

Q.9. Please elaborate on specific strategies you will deploy to address the dental services gap Kansas has in the Medicaid population, particularly in the rural and frontier areas.

A.9.

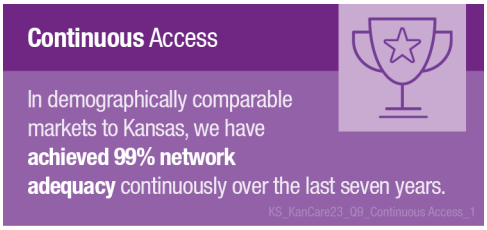
As a leader in whole person health care, CareSource takes an innovative and proactive approach to dental health services, tailored to each Member's individual needs. We cultivate an excellent dental Provider experience, incentivizing value, and quality to ensure our Members have access to culturally competent care. We overcome barriers to care through awareness, education, co-location of services, and transportation. Our experience combined with our collaboration with Oral Health Kansas and community needs assessments, will ensure we achieve similar increased access results in Kansas upon award.

Specific Strategies to Address Dental Services Gap in Kansas Medicaid Population

To achieve our goal for comprehensive dental health services, CareSource will leverage our vast experience and deploy key strategies to address dental services gap in Kansas.

Provider Recruitment and Enhancing the Provider Experience

CareSource intends to address existing dental barriers such as dental professional workforce shortages, especially in rural, frontier and areas such as south and west of Hays, retiring rural dentists, and limited dental schools in the region through our Provider strategy. We have developed a strategy inclusive of value-based incentives, student loan repayment programs pilots, and other incentives for new dental Providers in the region. Additionally, to combat dentist workforce shortages, we ignited work with dental hygiene schools and recruitment of more Kansas Extended Care Permit (ECP) Dental Hygienists who are key to addressing prevention and filling in access gaps. Additionally, we offer:



- **Provider Resources:** Increasing health equity and providing culturally and linguistically sensitive care are central to our VBP programs. Our team of dental directors, behavioral health, medical, and public health professionals developed a comprehensive toolkit to assist dental Providers with the tools and resources necessary to guide a Members' journey to better health and well-being. Toolkit topics include talking to Members about improving dental and physical outcomes through a drug-free, smoke- and tobacco-free life, and techniques on motivational interviewing to help overcome dental care hesitancy. We also offer cultural competency small group facilitated training and free continuing education for dental Providers. We encourage dental Providers to complete the U.S. Department of Health and Human Services' Cultural Competency Program for Dental Health Professionals, a free online educational program.

- **Provider Select Suite Solution:** CareSource is also evaluating the use of a program, in collaboration with our Dental network partner, to evolve dental VBP programs in Kansas. The Provider Select Suite highlights initiatives to improve Member and Provider Satisfaction, identifies and recognizes high-performing Providers, and helps direct Members to highly rated Providers. This guidance leads directly to increased Member and Provider satisfaction and substantial cost savings. One solution within the Provider Select Suite is the Provider Rating Tool. The rating process is currently built into an existing, State-approved VBP program, which allows us to provide support, data, and analytics for our VBP program. The tool automatically measures and rates Providers for quality, appropriateness of care, and efficiency based on your program's unique goals. The tool includes configurable criteria

based on claims history, authorization approval percentages, electronic adoption, and more. This tool can also incorporate any external data to apply to the ratings, for example, Member survey information could include Net Promoter Score (NPS) for each Provider.

- **Implementation of Dental Access and Availability Plan (DAAP):** The CareSource DAAP is for ongoing assessment and monitoring of KanCare service areas to ensure our participating dental Provider network is compliant and exceeds the KDHE network adequacy requirements and can deliver on our commitment to increase access and utilization of preventative dental as well as other essential oral health treatments and services.

Dental Quality Rewards VBP Program

CareSource will bring our Dental Quality Rewards program to Kansas. Through this program, we provided enhanced adult dental benefits and incorporated program initiatives with an investment of $27 million in Ohio and Georgia. This investment expanded preventive dental care and treatment utilization, resulting in improved oral health and improved overall health outcomes for Members with diabetes and pregnant Members, while reducing ED visits for nontraumatic dental conditions (NTDC). As an example, in the six months since implementing our Dental Quality Rewards program in Georgia, we increased preventive dental visits by more than 15%. Our Dental Quality Rewards VBP program includes:

- **Dental Home Provider Quality Rewards for Cavities Risk Assessments and Preventive Care:** This quality rewards program offers dental Providers the unique opportunity to improve clinical outcomes and receive compensation for their efforts in disease prevention and reduction in associated risks for dental cavities and adverse oral health outcomes.

- **CareSource MedDental™:** Our whole person coordinated care dental program will be implemented in two phases:
  - **Phase 1*:*** We will identify Members with specific conditions (e.g., diabetes, hypertension, respiratory illness, pregnancy) and dental care gaps, to provide support through innovative care coordination, health coaching, and covered dental benefits linked to improved overall health outcomes. The program also identifies Members utilizing the ED for non-traumatic dental conditions (NTDC) and provides outreach for follow-up dental care.
  - **Phase 2 (planned for 1 year, following Phase 1)**: We will offer incentives for interprofessional collaboration with coordination of medical-dental-behavioral health referrals, and care coordination at the Provider level. This will increase patient awareness of and Provider attention to the whole-person approach to helping Members attain optimal overall health. The program links value-based compensation to care coordination at the practice level and quality measures noted along with enhancer codes.

Increase Dental Health Awareness for Members

CareSource takes a multi-pronged approach to improving Member awareness and understanding of dental benefits and the impact oral health has on overall well-being and quality of life. Education begins at enrollment by completing a HRA to identify gaps in dental care and address barriers to access. Our multi-model outreach includes information on dental health, covered and comprehensive benefits, and how to access care, available in our welcome kit and Member handbook (available in all threshold languages), by mail, and on our Member website.

We support Members with selecting a dental Provider and assist with free transportation for dental visits. To incentivize Members to use their dental benefits, we offer our Member-incentive SmilePack with dental hygiene aids, education, and a $25 gift card for completion of their annual visit. We provide ongoing education to Members about dental care with these strategies:

- Call campaigns by county to Members who have not used their dental benefits to explain benefits, assist with locating a dental Provider, arrange transportation, and answer questions
- Newsletters distributed via text, email, or mail, based on Member preference, with education on dental care and covered benefits
- Informational texts with dental health reminders, tips, links to our Find A Doctor tool (where dentists can be selected as a Provider type), and other resources
- Postcard reminders with information on area dentists and targeted mailers to special populations (i.e. pregnant individuals, older adults, and Members with diabetes)
- Information prominently displayed on our website explaining free transportation for dental visits along with fun and engaging dental hygiene videos
- Advertising campaigns to raise awareness of the importance of preventive dental care Partnerships with community-based organizations to increase awareness and access through dental health education events and dental clinics, with onsite CHWs to engage with Members and provide additional support as needed

Closing Gaps in Dental Care

After identifying a gap in services for oral health in a juvenile justice setting, CareSource **committed resources to educate this population on the role good oral health plays in overall health and the overall ability to succeed in life enabling Oral Health KS to present "Success Begins with a Smile,"** to 24 young individuals residing in Wyandotte County Juvenile Detention Center in Kansas City, Kansas.

KS_ KanCare23_Q9_Closing Gaps in Dental Care_1

Coordinating Care for Dental Services

We take every opportunity to ensure whole-person health, including connecting Members to medical and dental homes; assessing for HRSN barriers, special needs, and medical complexity; and monitoring utilization of benefits. CareSource will contract with FQHCs and clinics throughout the State which have dental services onsite or in a mobile capacity. We prioritize connecting Members to these locations to receive physical health, behavioral health, and dental services in one location.

In addition to initial outreach and care coordination engagement, we utilize CHWs for outreach to Members with identified gaps in dental care. All staff have access to our GuidingCare care coordination platform for a complete picture of the Member's health history. Using motivational interviewing, staff identifies concerns, hesitancy, or barriers in accessing care. Staff review claims and identify dental related issues. Using our Find A Doctor tool, we help Members identify a dental Provider who meets their needs, such as language, accessibility, location, race and ethnicity, gender, and services offered. We can conduct a three-way call with the Member to a dentist's office to make an appointment, and we will help arrange transportation to the appointment, as needed. The team sets a reminder to call the Member the day before their appointment and follows up the day after to ensure the appointment was completed. In the event of a missed appointment, we follow-up with the Member to identify and address barriers such as transportation and help reschedule the appointment.

Stakeholder Partnerships and Community Engagement

Increasing community partnerships and activities that promote access to care, oral health education, and social support to promote oral health equity is at the core of our mission. By partnering and linking with community organizations, professional associations, schools, and community resources such as

foodbanks, education assistance and other organizations, CareSource promotes access to dental care and preventive services, and access to determinants such as nutrition, education and housing that support oral health outcomes. These partnerships play a powerful role in raising awareness about the importance of good oral health.

Collaborating with Oral Health Kansas
CareSource has worked closely with Oral Health Kansas to provide feedback on initiatives, gaps in care and educational resources. Partnering with Oral Health Kansas helps us promote not only access to dental care and preventive services but also address SDOH and to raise awareness about the importance of good oral health for Members. Below are a few of the initiatives that CareSource and Oral Health Kansas will continue to partner on.

- **"Begin with a Grin" campaign**: CareSource plans to promote medical dental integration with our Provider network. This program trains medical professionals to provide preventive oral health services for high-risk young children to decrease dental disease and reduce oral health disparities.

- **Dental Passports Program**: Parents fill out the passports with the necessary information related to their child's disability or health condition, as well as their likes and dislikes, certain things that make them happy, special in office conditions they would need, etc. The passport is then provided to the dental office prior to their visit. This information helps the provider to be prepared for the member's visit and to help make the visit as comfortable as possible. The Passport could include things like keeping the lights dim, turning off the music, etc.

- **Kansas Initiative for New Dentists Program (KIND)**: CareSource will make an investment to assist the KIND Program. The loan forgiveness program from the Kansas Dental Association (KDA), Kansas Dental Charitable Foundation (KDCF), and Delta Dental of Kansas encourages dentists to practice in rural Kansas. The program offers a Dentist Loan Forgiveness Grant of up to $50,000.

- **TeamSmile:** In Collaboration with Oral Health Kansas, CareSource recently sponsored an event providing free dental care for over a hundred students in Wyandotte County through TeamSmile**.** The event occurred in conjunction with the Kansas City Chiefs, Oral Health KS and TeamSmile, a national non-profit organization that provides free dental care and education for underserved children. CareSource will partner with TeamSmile and Oral Health Kansas to host its first Kansas exclusive event on June 18, 2024, with the Kansas City Monarchs. We are committed to a yearly event through TeamSmile and Oral Health Kansas in Kansas City and are proposing a similar event with the Wichita Wind Surge.

Children's Oral Health Institute Lessons in a Lunch Box: Healthy Teeth Essentials & Facts About Snacks®
Our goal is to educate not only Members on the importance of oral health, but the entire community on the importance of oral health. Lessons in a Lunch Box is an oral health literacy event, created by the Children's Oral Health Institute, to help children learn early about the importance of taking care of their teeth, healthy eating and snacking, and potential dental careers.

CareSource presented to 2nd and 3rd graders at a local elementary school. The day featured videos and interactive dental-related activities that included brushing and flossing lessons, a discussion about sticky plaque and how to make healthy food choices. Every attendee received an orange lunch box designed exclusively to teach elementary school children about oral health, healthy diets and encourages interest in careers in the dental profession. The brightly colored orange lunch box includes a color coordinated carrot case with a rinse cup top designed to store a toothbrush, toothpaste, and dental floss. The lunch

box also included oral health information for their parents. Teachers received oral health information and resources, as well as information on what to do in situations of dental trauma and emergency. We will implement this program in Kansas Unified School Districts.

CareSource has also helped to review items and make recommendations for Oral Health Kansas's Dental Passports program. Parents fill out the passports with the necessary information related to their child's disability or health condition, their likes and dislikes, certain things that make them happy, special in office conditions they would need, as well as other preferences. The passport is then provided to the dental office prior to their visit. This information helps the Provider to be prepared for the Member's visit and to help make the visit as comfortable as possible. The Passport could include things like keeping the lights dim, turning off the music, etc.

Rural and Frontier Areas Strategies

We will leverage our extensive experience to ensure timely access to quality dental care in urban, rural and frontier areas. Our proven interventions to increase access in these areas will assist Rural and Frontier Members with timely access to dental care.

Deploying the Dental Home Model

One of CareSource's key evidenced-based programs for improving access to care and implemented in several State markets is **Dental Home is Where the Heart Is ™** Our program leverages the Dental Home Model to create an ongoing relationship between a dental care Provider and a Member, similar to a primary care physician in health care. By establishing routine checkups every six months and treatment, when necessary, Members are provided with preventive oral health care that diminishes their risk of dental disease and establishes overall health and longevity. This is an essential solution for Kansas as the foundational goal of this model is to ensure that the Medicaid population we serve, in all geographic regions of the state, are assigned to or self-select either a general or pediatric dental office. We educate Members, caregivers and Providers on the features and benefits of the dental home model.

In implemented markets, the program has resulted in a **5-10% increase over the last three years, in measures tracked annually.** Children received oral health education and CareSource SmilePacks (oral hygiene kits with battery operated toothbrush, floss, other aides, and oral health education brochures). Both children and adults can also receive gift cards up to $20 per year for having their dental check-ups.

We will identify all Providers in Kansas who are eligible to serve as a Dental Home (i.e., General or Pediatric Dentists), and work diligently to increase the Medicaid participation rate. CareSource will auto-assign a KanCare Member to a dentist with whom, the Member has a historical relationship, provided regulatory geo-access requirements are met. However, Members will have the option and flexibility of selecting or changing their dental home. If the Member has no historical relationship, CareSource will auto-assign the Member to the assigned dentist of an immediate family Member also enrolled in CareSource as age appropriate. If no immediate family member has a historical relationship with a dental Provider, CareSource will auto-assign the Member to a dentist using an algorithm that is based on the age of the Member, geographic proximity, and Provider panel size.

Mobile Dental Van – Reaching Rural and Frontier Areas

CareSource Wellness on Wheels (WOW) is our experienced mobile health unit launched in Georgia where we created multiple partnerships with mobile clinics to serve rural and high-need communities. In 2023, the impact of CareSource WOW was hugely significant with over 15 WOW health stops, hosting more than 15,000 attendees. CareSource has committed to incorporate a Mobile Sprinter Dental Van that

will be used in partnership with contracted FQHCs and Community Centers serving the frontier and rural regions of Kansas. We will partner with mobile dentist through an enhanced fee schedule arrangement to provide mobile dental services throughout Kansas.

CareSource's Virtual Dental Home Collaborative

One strategy to increase access to care in Medicaid populations and specifically rural and frontier regions in Kansas, CareSource will launch its **Virtual Dental Home Collaborative**. The Virtual Dental Home initially launched in CareSource's Georgia market to assist in access to care gaps, encompasses components of the "brick and mortar dental home," but does so using geographically distributed, telehealth-connected teams. The **Virtual Dental Home Collaborative** through mobile dental equipment and technology donations provided by CareSource, uses technology and innovations in the workforce to bring safe, high-quality dental care to children and adults where they already spend time, such as at schools, early learning sites, skilled nursing homes and other sites in the community.

CareSource partners with public health programs and safety net clinics, operating per state mobile and telehealth practice acts, looking to improve the oral health and dental care of the population they serve. The program promotes expansion of the Provider's capabilities to bring safe, high-quality dental care to individuals where they already spend time in the community. Most importantly, it brings much-needed care and preventive services to individuals who might otherwise receive no care.

In Kansas, the Extended Care Permits (ECP) I, II and III workforce model that has expanded the dental hygiene scope of practice, allowing dental hygienists to provide oral care to Kansans in different settings beyond the dental office, is an optimal opportunity to incorporate the **CareSource Virtual Dental Home Collaborative**, as studies show the ECP workforce model in Kansas through the years has resulted in a dramatic increase over 50% in patient contacts in safety net clinics, a main hub for many ECP Providers. Training and implementation of the Virtual Dental Home Model is supported by CareSource.

Kansas community partnership targets include:

- FQHCs
- School-based health clinics (SBHCs)
- Community Health Centers (CHCs)
- RHCs
- Local health departments or agencies
- Volunteer community health setting
- Post-secondary educational institutions, (Kansas City University Residency programs)
- Skilled nursing facilities, Senior centers
- Family violence shelters
- Juvenile Justice System programs

We will also:

- Collaborate with general dentists in rural areas to identify any dental specialties that are qualified to perform and credential them appropriately. These specialties can be included as part of their listing in the Provider directories and that information is available to help Members find the dental services they need.
- Work with non-participating specialty dental Providers to arrange services in areas of need via single case agreement to ensure access to Members and provide opportunities to transition to in-network Providers; this contact with non-participating Providers can also lead to discussions regarding becoming a contracted or participating Provider. These situations are often handled through a single case agreement, where specific fees and services are agreed to with the Provider on a one case basis to see the member in needed. However, these situations often lead to out-of-network Providers joining our network.

We have a number of key partnerships in our current dental network. Currently, we partner with at least two larger oral surgery groups, both of which have hospital privileges, to allow for the more complex

dental cases to be handled in a hospital setting. There are two rural counties where we have a Provider contracted that is the only dental Provider in their area. We have also partnered and contracted with a number of mobile units and FQHCs in the state of Kansas as well as the largest dental Provider group in the State.

CareSource is also exploring a number of innovative solutions with [redacted] to bring value-added solutions focused on Member and Provider satisfaction, a streamlined experience, and services specific to IDD (Intellectual/Developmental Disability) Members.

Q.10. Please describe how the members in the health alliance model would be structured/work coordinated, including what level of staff would have ultimate accountability for them. Also, describe how you would address potential conflicts of interest.

A.10.

CareSource seeks to transform healthcare from reactive to proactive and from fragmented to comprehensive, which is why we established the **CareSource HealthAlliance**. The alliance is composed of three prominent and well-respected statewide nonprofit organizations with deep Kansas roots that understand and address the unique needs of the most vulnerable: The Children's Alliance, InterHab, and ACMHCK (collectively, our HealthAlliance Partners). Key components of our HealthAlliance include:

[redacted]

CareSource HealthAlliance Governing Structure

[redacted]

CareSource HealthAlliance Work Functions

CareSource HealthAlliance Structure

[redacted]

Preventing Conflicts of Interest

[redacted]

Q.11. With the health alliance model, please provide an outline of the approach you would take to assure all information technology systems are integrated and tested for readiness for a January 1, 2025, go-live. Please briefly describe the “modern” data platform that is mentioned in the bid response.

A.11.

[redacted]

CareSource’s Proven Implementation Success

We are confident in our ability to successfully meet a January 1, 2025, go-live. Our IT systems readiness is the foundation of our program implementation success and **has enabled CareSource to meet 100% of the readiness requirements** to implement Medicaid procurements and re-procurements for over 2.1 million Members in the last six years. We will leverage this experience and our proven success as we implement the KanCare Program.

Flawless Implementation

On April 12, 2023, CareSource and the Health Alliance Plan of MI announced a new Joint Venture to serve Michigan Medicaid members. Over the next 6 months, **more then 780 staff across CareSource operations provided the State a seamless implementation**. This implementation included full configuration of all Michigan Medicaid edit and audits, transitioning thousands of providers to our Guiding Care platform, and ensuring our members were aware of their changing plan and knew where to seek assistance. On Oct. 1, 2023 **HAP CareSource went live with zero disruptions in care**, no significant increases complaint volumes, and a significant increase in operational efficiency including **increased auto adjudication from 81% to 98.3%** and **first pass claims accuracy starting at 98.3%** on day one and i**ncreasing to 99.5% through first 6 months of operations**.

KS_ KanCare23_Q11_Flawless Implementation_1

We recognize some MCOs in Kansas have historically experienced challenging implementations and **we have proactively initiated work with our HealthAlliance Partners to ensure a seamless and hassle-free implementation for KanCare.** At program transition, we will focus our resources to ensure Members continue to get uninterrupted current services, and ensure Providers get paid accurately and quickly for continuing to deliver those services. Our approach and technology systems prevent Member and Provider disruptions and do not allow service or Provider changes until an updated person-centered comprehensive needs assessment may require change.

Our modern data platform, explained in more detail later in this response, is a single system of record linking all Member and Provider data elements (both real-time and historical) and allowing 24/7/365 access and support for our Members, their caregivers, Providers, and CCCs. Unlike most MCOs who have multiple systems and platforms that must be configured and retrofitted for each state implementation, **our single system of record is easily and rapidly configured and tested prior to any go-live.**

Successful Implementations over the Past Six Years

Implementations	Member/Population Focus	~ # of Members at Implementation
2023 — Michigan	Adults and children up to age 19	90,000

Implementations	Member/Population Focus	~ # of Members at Implementation
2023 — Indiana Medicaid	Children up to age 19, pregnant women, families, and expansion program covering uninsured adults, ages 19 – 64	150,000
2022 — Ohio Medicaid	Children up to age 19, behavioral health care for certain patients under the age of 21, and adults	1,300,000
2022 — Arkansas PASSE	Children and adults with intellectual and developmental disabilities and complex behavioral health needs	2,500
2018 — Indiana Healthy Indiana Plan (HIP) 2.0	Expansion program covering uninsured adults ages 19 – 64	75,000
2017 — Georgia Medicaid	Children up to age 19, pregnant women, newborns, women under 65 with breast or cervical cancer, adults, and refugees	425,000
2017 — Indiana Medicaid Hoosier Healthwise (HHW)	Children up to age 19, pregnant women, and families	75,000
2017 — Indiana Medicaid HIP	Expansion program covering uninsured adults ages 19 – 64	75,000

Approach to Readiness

CareSource's thorough readiness review process **guarantees all necessary elements are in place for a successful launch.** Out of consideration and respect for KanCare staff and their time, we intend to conduct an internal readiness review before any KanCare-led readiness activities, ensuring preparedness. Our proven and successful internal readiness review includes examining all elements necessary to ensure a successful go-live. We verify testing results, complete an inventory of deliverables, confirm requirements and implementation plan tasks line by line, and walk through all facilities, processes, and system functions. Once ready, we will follow KanCare's lead and provide all demonstrations, artifacts, and requested proof of ready status.

[redacted]

[redacted]

Proven Testing Process

Our agile team is ready to meet all KanCare timeline requirements for submissions and response file analysis based on State dictated timeframes. Our teams, typically consisting of architects, developers, testers, and other relevant roles, use a single team board with stringent standards to visualize and manage their work. We maintain rigorous and high-quality testing across all development phases, from scrutinizing code at its foundational level to conducting user acceptance and scenario-based end-to-end testing.

In adherence to quality standards, the assignment, refinement, and execution of test cases are fully traceable to requirements. These records are readily available at our team boards for regular audits, ensuring compliance with built-in quality standards. From contract initiation through to releases, and partner testing (including, but not limited to, 820, 834, 837, and all other file transfers), our process, customized to KanCare contractual requirements, includes regular product and project demos every 10 days, where business owners approve all changes. This ensures transparent and continuous stakeholder engagement and certification throughout the development lifecycle.

This meticulous approach to left shift release readiness ensures that our deliverables are fully prepared for deployment. This close coordination between business and technical experts throughout the software development lifecycle guarantees precision and accountability pre-production and post-production.

Modern Data Platform

CareSource's modern data platform is our single system of record and real-time data repository. We describe the platform as "modern" because it:

[redacted]

The following graphic depicts an overview of our modern data platform inflows, capabilities, and outputs available to the State to manage both population health and overall operational performance.

The result is a centralized source of truth for data that enables actionable insights enhancing our ability to anticipate, take action, and coordinate care on behalf of our Members like no other plan can. Our technology drives transparency, innovation, and higher quality data through a holistic view of insights,

performance, and meaningful outcomes at the Member, Provider, and regional levels. This approach ultimately reduces administrative burden and drives reporting and data governance excellence.

Capabilities and Process to Support Actionable Information

Our architecture includes technologies for automation, advanced data science, and scalability. It is the very foundation for complete and accurate reporting. It supports data gathering for all business programs, including population health initiatives, UM, grievances and appeals, enrollment and disenrollment, Member and Provider hotlines, authorizations, claims management, SDOH, and benefit administration. We designed the infrastructure to purposefully scale, addressing market and regulatory changes while accommodating the volume of processing data and the workload associated with outcomes and data reporting.

We deliver reports satisfying all regulatory requirements using Microsoft Power BI and SQL Server Reporting Services. We tailor and customize reports, satisfying both interactive self-service and targeted ad hoc needs. We build and use analytical dashboards for our internal leadership and offer customization according to the State's preferences.

Predictive Models and Algorithms

Data within the modern data platform powers our advanced risk stratification algorithms. Our algorithms [redacted] developed by our dedicated Data Science team experts comprised of statisticians and artificial intelligence/machine learning experts. Our capabilities enable proactive population health by early identification of healthcare risk driving outcomes for effective care coordination intervention. Two specific examples of how we use our real-time modern data platform and proprietary models to inform our population health management approach are detailed below:

- [redacted]

[redacted]

CareSource's Modern Digital Ecosystem

Our modern data platform is vital component of our larger modern data digital ecosystem which was purposely built for Medicaid and is fully integrated and upgraded. Comprised of best-in-class technology/modular systems and coupled with our modern data architecture, our digital ecosystem enables us to scale vertically and horizontally, easily supporting specific program and population needs and increasing reporting needs. **It also promotes our delivery of industry-leading operations, which are among the best in the nation**, as demonstrated below.

Industry Leading Operations

Provider Satisfaction

93% Provider
Satisfaction Rate for call resolution.*
* Year to date

Dental Vendor Provider Satisfaction

82.30%
very satisfied/satisfied
(anything above 80% is considered very good)

Providers Report High Satisfaction

91% Respondents
would recommend CareSource to other physician practices, leading all plans

First Call Resolution Rate
over 93%
in Indiana, Ohio, and Georgia

Quality Achievement Award
CareSource Days Group in 2022:

40%
improvement in quality outcomes

91% Members
stated educational materials, guidepost-informed care coordination encounters, and other program processes helped them in achieving their health goals.

Disease Management Survey

95% Members
with diabetes stated they understood the importance of daily blood sugar monitoring and **92% understood the need for an annual eye exam and regular A1C testing.**

Disease Management Survey

93% Members
rated the satisfaction of their experience with our overall Care Coordination program as high, and **90% rated their satisfaction with the Care Coordination team as high.**

Care Coordination Survey

Operational Excellence

Claims
- **99%** of behavioral health claims paid in less than 5 days
- **98%** of all claims paid in less than 3 days
- **98%** auto-adjudication rate
- **>99%** first pass accuracy

Grievances
- **98%** of complaints/grievances less than 30 days

Appeals
- **99%** of appeals completed within 30 days

Disputes/Complaints
- **99%** resolved in less than 25 days

Average Closure Times
- Grievances: **10 days**
- Appeals: **11 days**
- Disputes/Complaints: **10 days**

KS_KanCare23_Q11_Data Results_4

[redacted]

These capabilities enable real-time sharing of information between the State, Providers, community-based organizations, and care team members. They create multiple channels for Provider and Member interaction and support automatic and bidirectional data exchange to arm Providers with the latest information they need to design and communicate the right PCSP for Members. They also efficiently and effectively enable Medicaid program administration, from claims processing to Provider data management, clinical care coordination, customer service, program integrity, and compliance.

The graphic on the following page depicts the technology components that comprise our IT platform. It also provides a crosswalk of major operational functions to the technologies that enable them.

[redacted]

Q.12. Please outline the criteria you use to determine the placement of Community Health Workers. Please describe how you will collaborate with the Medicaid team on Community Health Worker strategies/deployment?

A.12.

CareSource considers CHWs, *both directly employed and Provider/community based*, priority practitioners in our integrated whole-person care model. CHWs have a close understanding of their communities and are uniquely equipped to act as an integral part of our Care Coordination team and as extenders to community Providers. The CHW's trusting relationship with the Member enables them to serve as a link between healthcare, social services, and our community and to bridge the trust gap and allow for real health improvement to thrive.

Data-Driven Approach in Determining Placement of CareSource CHWs

CareSource leverages multiple sources of data to determine placement of CHWs and avoid duplicating services. One source we use is the State's CHW Coalition (KSCHW Resources) map allowing us to ensure needed services are met throughout the State. Additionally, we identify opportunities for CHW placement through:

- Data and insights from our population health assessments (described below)
- Feedback from the State on targeted areas of interest
- Input from public health departments, RHCs/FQHCs, and other care coordination entities to identify potential CHW placements
- High-volume Providers (with Member panels of 500+) who need support with scheduling visits, arranging transportation, or arranging services and/or resources to close care gaps
- EDs with high volume and/or significant behavioral health volume
- Hospitals with high inpatient volume and/or high volume of pregnant Members
- Care coordination centers that require additional staff to assist with Member needs during regular business hours
- Data shared from Food Banks, Continuums of Care and local community-based organizations
- Retail organizations (e.g., Walmart) where CHWs can assist Members with resource navigation
- Placing CHWs in schools to work collaboratively with the Mental Health Intervention Teams and guide them to resources such as SparkWheel
- Attach CHWs to large correctional facilities for Members reintegrating into the community to guide them to the resources they will need to be successful

We leverage an evidence-based population health assessment framework on an annual basis to improve the health of the population, Member care and experience, and to target strong community partnerships. The data becomes available through our Population Health Dashboard that allows us to look at the State's landscape and determine best placement for CHWs depending on need. The analysis of qualitative and quantitative data helps to prioritize key population health strategies to develop specific action plans including the deployment of resources such as CHWs.

During our collaboration meetings with the State and Community Based Care Entities, we share the population health assessment to develop strategies and interventions while ensuring no duplication of services and to help allocate resources. CareSource's CHWs proactively reach out to Members through interactive telephone calls and text messages to remind them of screenings or care gaps and inform them of wellness resources. We also utilize CHWs to conduct monthly outreach calls, including cold calls to Members; distributing plan materials on doorknobs; and working with Care Coordinators to update contact information in the Member's record. If the Member is enrolled in HCBS, the CHW will collaborate

with those Providers when they are in the home to determine an opportune time to outreach to the Member. Using strategies like the ones described above have significantly increased the number of Members we are able to initially engage and keep engaged.

Preventing Unnecessary ED Utilization
CHWs work with Members to address preventable ED utilization, such as where to go for care and using Members' PCP, behavioral health home, and dental home through our ongoing ED QI project. Our CHWs, in consultation with Care Coordinators, collaborate with Members to help understand the importance of establishing a trusting relationship with their Providers, when to reach to the CareSource24® nurse advice/behavioral health line, and other alternatives to using the ED for primary care to avoid unnecessary utilization.

CareSource also hires CHWs based on their familiarity with the patient population, seeking CHWs that reflect the diversity within the community, including community resources in the rural area that surrounds the hospital. We train CHWs in motivational interviewing, SDOH, health care delivery, and system navigation. They collaborate with nurses, Providers, pharmacists, care coordination team, and social workers. For Members in the Citizens Medical Center ED with psychiatric conditions, CHWs provide social support, navigation, coaching, care transitions support, and referrals to social services.

Assisting Hospitals with Discharge Planning
CHWs may also reach out to increase Member engagement in adherence to follow-up appointments after an inpatient admission. Our CHWs assist Members through the following interventions at the direction of the Care Coordinator upon or near discharge:

- Call Members two days prior to remind them of 7-day and 30-day appointments
- Confirm Members kept their follow-up appointment with qualified outpatient Providers
- Assist Members who miss their follow-up appointment to reschedule
- Address social barriers, such as transportation, to support Members in attending appointments
- Assist Members to connect with a tele-behavioral health Provider if they prefer

Connecting Members to the Community with Care Coordination Centers
CareSource understands the importance of having Care Coordination teams located in the communities where our Members live. This strategic, regionally based approach with our Care Connection Centers enables our Care Coordination team to easily conduct Member outreach help Members and their informal supports receive concierge services at any time[redacted]

Our Care Connection Centers provide shared community space where CareSource Care Coordinators, CHWs, Life Coaches, and CCCs can collaborate, receive training, and hold case conferences and ICT meetings. It will also include space for Kansas agency staff when they are onsite. In addition, Our Care Connection Centers serve as SDOH resource centers, health education hubs, and conference space for meetings with community-based organizations. In these locations, CHWs can support Members in identifying SDOH needs, coordinating services to address them, as well as assisting with completing applications for community resources. They also help connect Members to WIC, SNAP, and other state and federal programs.

The CareSource HealthAlliance was built to augment the expertise of our community partners and leverage their lessons learned through their years of supporting clinical extenders. We recognize the contribution CHWs bring to the community as an integral part of our care coordination team and as extenders to community Providers. We invest in training and professional development for CHWs due to their ability to help us understand the strengths, concerns, and needs of the different communities we

serve. CHWs are valuable assets to both our CareSource care coordination model and the CCCs and Targeted Case Managers.

Retail Organizations
In partnership with Walmart, we have created *Wellness My Way*, an integrated care model that uses CHWs to address both social service gaps and identified care gaps in the communities where our Members live. This strategic program is built to provide additional support from Walmart CHWs for our Complex Health populations such as (but not limited to); individuals on the IDD waiver and IDD waiver waitlist, pregnant mothers, families at risk for foster care involvement, with the option to add additional high needs or hard to engage populations in the future.

Wellness My Way is a blended and seamless engagement for our Members, to receive CHW assistance with coordinating services, attaining access to telehealth services, connecting to preventative and dental care, supports through community resources, while also remaining connected to CareSource through Care coordination, Coaches through our Life Services® program, CareSource 24, and more.

In addition, as part of this endeavor, CareSource and Walmart have created impactful and immersive, rich experiences called SHARE (Special Health Access Retail Entertainment) Days. These experiences are created to support advancing health equity in the communities we serve. By partnering with national brands and local community-based organizations, CareSource and Walmart create these experiences to provide information, education, resources, grounded in the spirit of a fun and celebratory atmosphere. Our work with Walmart has created unique events around maternal, child and family care, caregivers and overall health and social driver support. In 2023 we hosted six SHARE Day weekend events that engaged over 7,000 Members across four states, which included over 200 workshops, screenings, and wellness info sessions that included over 50 community partners sharing info as well.

Family Resource Centers
Family Resource Centers in Kansas serve as community hubs with the sole purpose of supporting families in their own neighborhoods. To give children and families awareness and access to CHWs in their own communities, we will place CHWs specializing in family care, system navigation, and preventive care into family resource centers around the state. Since Family Resource Centers are trusted entities in communities, we know that families turn to them in times of need, to access early childhood and job skills programs, and nutrition support, we aim to work closely with these entities to better support families and help them gain access to necessary services. In addition, Family Resource Centers have proven to build families capabilities and prevent foster care involvement, which is a top priority.

Specialized CHW Programs
Members have shared their need for improved resources for employment and education. In response, CareSource deployed specialized programs to target populations to complement our use of outreach modalities to those in local communities. The following are examples of specialized CHW programs for those experiencing unique and challenging conditions:

- Maternity
- Foster care and those at-risk for foster care entry
- Individuals on the IDD waiver and IDD waiver waitlist
- Elder care
- Justice involved youth and adults

Collaboration with Medicaid team on CHW Strategies and Deployment

CareSource and our HealthAlliance Partners have a long history of collaboratively engaging KDHE, KDADS, and DCF with the goal of exceeding expectations by proactively identifying and addressing the State's needs. We are committed to working with the Medicaid team through a consultative approach benefiting our Members, their families, and our local communities. We will have dedicated staff who will partner with the State on these efforts. We will also designate key organizational leadership and national experts to bring relevant local and national expertise to Kansas to expand the adoption of CHWs, particularly in traditionally underserved locations across the State.

In partnership with the Medicaid team, we will build on relationships with local stakeholders and our HealthAlliance Partners' years of experience utilizing clinical extenders to build a CHW/CHR workforce within the state of Kansas. Some specific areas of collaborative interest include:

Collaborating on the Development of Analytics and Reporting to Prioritize Program Development

As mentioned in our response above, CareSource intents to use our proprietary HCBS Gaps Dashboard to identify locations where we can focus efforts on the development of the CHW program for the specific purposes of filling gaps in the system of care. We welcome the opportunity to partner with the Medicaid team and other MCOs to collaboratively develop the analytics that are consistent across plans and intended to "Hot Spot" areas for shared improvement. Our current dashboard utilizes multiple data sources such as approved PCPSs, authorizations, claims, and EVV data to confirm services are delivered based on need, frequency, and duration of the service as per the Member's approved PCSP. Other exterior data sources as described in Q.13. below may allow for a more refined analysis of where CHWs should be deployed.

Collaboration on Training, Certification, and Higher Education Pathways

As an integral part of the CareSource model of care for all Kansans, CareSource intends to collaborate with the Medicaid team to provide initial and continued training support of all CHWs and CHRs, both as our Staff and those seeking employment with community Providers and other community-based organizations.

One example of this collaboration took place in 2021. The ACMHCK, one of our HealthAlliance Partners, worked with KDHE to approve a CHW training program through the Kansas CHW Coalition, a certified Kansas CHW education Provider with a work experience pathway. These pathways were created for CHWs to pursue higher education and create jobs for individuals in the field of health science who may be interested in pursuing a bachelor's degree, scholarship, mentorship, MCO internship, or in need of clinical and community hours.

In other markets, CareSource has collaborated with State agencies and training providers to significantly increase the number of individuals receiving training as a CHW. For example, in Ohio, we worked with Central State University to provide training services to community members interested in becoming CHWs and patient navigators. Upon completion of this program, we hired approximately 5% of graduates while over 95% of CHWs from this program are employed by the community in places such as hospital systems, non-profit and faith-based organizations, public and private clinics, educational systems, learning extension centers, public agencies, and even serving clients within their own homes. We intend to replicate this success in Kansas by collaborating the Medicaid Team, the United Methodist Health Ministry Fund, and the Kansas CHWs Coalition to support the existing State training programs administered by WSU, MARC and Metropolitan Community College, and a new program being launched by Kansas State University.

Developing Key Performance Indicators

As the CareSource team looks to provide oversight and management of program design, implementation, and ongoing monitoring, we look forward to collaborating with the Medicaid team to develop key performance indicators. Some of these may include ensuring adequate staffing and staff training, ensuring adherence to all regulatory and compliance requirements, and appropriately reporting on program effectiveness to respective internal CareSource committees.

Q.13. Please elaborate on how you will contribute to and support the state in creating and publishing a timely and user-friendly dashboard of meaningful metrics for members and stakeholders of the Medicaid program.

A.13.

As a leader amongst MCOs in technology and operations, we will enthusiastically contribute to and support the State in the creation of a timely, user-friendly dashboard. Our background with systems and analytics allows us to collaborate as an experienced partner. As a result, our contributions significantly impact Members and Providers in a successful, informed, and innovative way. We use industry-leading technologies, enabling advanced data science that is real-time and bi-directional, to improve health outcomes, promote evidence-based medical care, and ease administrative Provider burden. We understand the importance of using data analytics and reporting to enable, contribute and support the successful operation of KanCare.

Creating and Publishing a User-Friendly, Meaningful Dashboard

We welcome the potential to convene and host other MCOs in this work, leveraging our vast experience and share the mastery of our data scientists to create the best tool possible for Kansas. We have a demonstrated record of accomplishment for timely, consistent, and accurate report submissions (both scheduled and ad hoc) for our State partner Medicaid programs. Our strong commitment to complete and accurate reporting ensures CareSource is driving positive results for our Members.

Leveraging on our past success, we can lead in the creation and publication that will improve the transparency of the Kansas Medicaid program, allowing Members and stakeholders to have a better understanding of program, payer, and Provider performance. Using our enterprise data platform, we consolidate data from multiple CareSource systems and from external sources to provide a concise, accurate, and complete data repository to meet all information needs. Our business intelligence platforms enable report and dashboard development using the data in the enterprise data platform, both for internal operational and analytical reporting and for regulatory and compliance consumption. These collaborative systems allow us to segregate data based on demographics, focused on rural/frontier areas, Members/Providers, HCBS/LTSS, personal care assistants, foster care population, waiver populations, and others, to avoid disparities that may appear in data. We can positively influence the Kansas dashboard to produce meaningful and useful data that will improve results for KanCare Members.

Based on our systems, our informed teams, and our experience, CareSource is confident our contribution to creating the KanCare Dashboard will be strong and useful. We commit to leading and delivering the collaboration and collective solution that will create better results for Kansans. Our teams look at the information to truly understand the data and the ability to utilize the right sources to drive results for Medicaid programs. Dashboards and maintenance are secondary to the information utilized to create reporting; our experience ensures results.

The internal Clinical Analytics team, which includes data scientists and data architects, provides insight and expertise for internal and external stakeholders. We base our team structure on critical areas of specialization, including population health management analytics, medical economics, clinical informatics, data science and predictive analytics. Our Operational Analytics team specializes in Provider network, VBP payments, and operational performance monitoring and enhancements. This structure enables data-driven decision making and provides an in-depth perspective into the most critical aspects of our Members and Plan performance.

Our predictive analytics is a toolset that feeds our Population Health Dashboard, an example is below, to identify Members at risk for maternal mortality and morbidity, behavioral health and other chronic diseases

and complex conditions. This provides insight to the specific challenges from each population. Our technology supports program efficacy by collecting data including geography, race, ethnicity, income, age, gender, language, disability, and SDOH to support identification of disparities in health outcomes in Kansas priority areas. For example, our innovative models include identification and stratification of Members with high-risk pregnancies as well as Members at risk for homelessness, readmission or at high risk for suicide in addition to Member specific SDOH indices (e.g., economic stability, education, etc.) for multiple Population Health Management efforts, including but not limited to asthma, diabetes, sickle cell disease (SCD), and other complex conditions.

Assisting Ohio Medicaid in Analysis and Cost Savings

Our technology drives transparency, innovation, and higher quality data through a holistic view of insights, performance, and meaningful outcomes at the Member, Provider, and regional levels. This approach reduces administrative burden and drives reporting and data governance excellence, as evidenced recently in Ohio. Ohio Medicaid introduced a fiscal intermediary in Ohio Medicaid effective February 1, 2023. The fiscal intermediary had the role of providing “one front door” that all Providers were required to use to submit claims to the Medicaid MCOs.

Based on CareSource’s analysis of the performance results of the fiscal intermediary, our teams built a dashboard to analyze results. The dashboard was presented to representatives from the Ohio Department of Medicaid (ODM) as we participated in a number of meetings. The dashboard was displayed for meeting attendees and our team walked through the real impacts of the fiscal intermediary on claim receipt patterns in Ohio. ODM was enthusiastic about the dashboard and scheduled to meet with us to review the newest results every four to eight weeks over a period of approximately ten months. ODM used the dashboards to review patterns and quickly dive into the details and problem areas of the

implementation and how to redirect the initiative. These are the collaborative dashboards designed with Ohio data to analyze performance results:

Continued Contribution to and Supporting Kansas

From the onset of our contract, CareSource will actively engage with the State to ensure the provision of accurate, timely, and meaningful data and reporting, ad hoc requests, and a customizable dashboard, including data points beneficial to the State, without inundating the State with superfluous reports and data. Our team will track the State's specific priorities, along with other clinical and non-clinical measures such as preterm births, infant and child mortality, immunization rates, and SDOH and independence. Some examples of the measures we track include:

- ***Clinical Measures*:** Potentially preventable ED visits and hospital admissions, appropriate treatment for children with upper respiratory infection, prenatal and postpartum care, weight assessment and counseling for nutrition and physical activity, immunizations, follow-up care for children prescribed attention deficit hyperactivity disorder medication, low birth weight, metabolic monitoring for children and adolescents on antipsychotics
- ***Non-Clinical Measures*:** Housing instability, lead exposure, food insecurity, transportation, potential health disparities and other non-medical determinants of health (SDOH)

- ***Member Satisfaction Measures*:** Rating of personal doctor, getting care quickly, access to routine care, and how well doctors communicate
- ***Provider Satisfaction Measures:*** Overall satisfaction with the health plan, recommending MCO to other physician practices, "Process for Obtaining Member Information"
- ***Operational Measures*:** Claims payment timeliness and accuracy, adverse determination rates, appeal rates, customer support average hold times, and first call resolution

CareSource will dedicate a Data Liaison to Kansas for this important work, who will serve as the primary data contact for the State. This individual will collaborate on Kansas' data analytics needs and facilitate additional insight and orientation on the use and interpretation of the data we provide. Our team understands the best ways to collect, analyze, and visualize the data. We are experienced with identifying the best metrics for tracking results and we can help establish standards for data collection for use in Medicaid dashboards and reports to help avoid the pitfalls of noncongruent submissions and data.

Our Data Liaison will meet at a minimum on a quarterly basis or as frequently as requested with the State to discuss priorities and requests and will be available to answer questions or provide assistance and recommendations. A State Dashboard, similar to the Georgia Medicaid Dashboard below, can be used in these meetings to analyze the KanCare program for CareSource Members. The Data Liaison will assist in supplying performance oriented and Member specific dashboards reporting on health and service utilization. Many of our organization's leaders actively participate in workgroups, committees, information technology, HIE advisory boards, and strategic initiatives across our many data-sharing partnerships. Our engagement in these groups, which dates back nearly a decade, demonstrates our longstanding commitment to collaborating with our State Medicaid partners. Using this engagement, we will invest in our partnership with the State and share our depth of experience, technical assistance, and unique ability to unlock additional value from technology and interoperability initiatives that support Kansas in achieving its priorities specific to Medicaid Members.

Our maintenance and use of data enhances our dashboard reporting. Our team of Data Scientists have learned from our analyses and can share our learning with the State to ensure results. We consistently look for and consider impact to our Members and Provider network using meaningful metrics such as Operational metrics, Member surveys, CAHPS® and NPS results, Member Advisory Council meetings and feedback to engage the Member in what is important to them. We maintain a multitude of internal dashboards based on these and other sources to track our performance against negative impacts. Our data includes inputs from multiple internal and external sources such as:

Internal Data Sources	External Data Sources
▪ The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment results ▪ Medical and pharmacy claims ▪ Guiding Care ▪ PAs ▪ HRA ▪ Prenatal risk assessment form ▪ Laboratory results ▪ CareSource24® nurse advice/behavioral health line ▪ SDOH screening and referral tools ▪ Member and Provider customer support data ▪ Member appeals and grievances ▪ Network access standards reporting ▪ CAHPS® Member surveys	▪ Direct Provider HER data from i2i & Azara ▪ Vital statistics ▪ 834 Enrollment File ▪ KSWebIZ- Kansas' Statewide Immunization Registry ▪ EVV data ▪ EHRs ▪ KHIN and LACIE ▪ ADT Feeds ▪ SDOH referral platforms (e.g., Find Help, Unite Us) ▪ American Hospital Directory

These data analytics and reporting capabilities enable our business operations to improve health outcomes, reduce medical costs, manage administrative costs, increase the ability to respond to market disruptors, expand value to Members, and efficiently react to state and federal changes. As a result of these developed systems and processes, we have a solid understanding of what our Members and our Providers care about most and we develop dashboards that provide our teams visibility into our performance on these metrics that matter. CareSource looks forward to collaborating with the State and the other MCOs on a robust data strategy for the KanCare program.

Q.14. Noncompliance reported in your bid noted areas where a pattern of issues occurred with reporting. Please elaborate on changes you have recently made to improve in this area.

A.14.

[redacted]

That said, we take these matters seriously and have implemented several improvements in our overall regulatory reporting process, specifically related to the timeliness and accuracy of data content, to ensure full compliance with State requirements and expectations. In addition to reporting our performance and risk mitigation activities to our executive leadership and Board of Directors, we recently implemented the following changes to improve in this area:

- We improved our report creation process with an **increased concentration on enhancing data sets and adherence to technical specifications.** This upstream process enhancement increases efficiency and allows our Compliance and Business Owners more time to review each report for accuracy and timeliness.

- We **upgraded our core systems and modern data platform** to enrich the accuracy of the reporting data sets and to streamline the report creation process to increase our reporting efficacy and consistency. Because our core systems reside on a single platform, we can produce reliable data efficiently and include additional reporting without significant burden to the organization.

- We created **designated teams across various functional areas** to specifically focus on the regulatory reporting process. Most recently, our IT team hired a Vice President of Data Strategy, a senior leader with over 30 years of experience, whose primary focus is enhancing the regulatory reporting process and bringing forth reporting accuracy improvements. Our Compliance team has also created a team of compliance experts whose sole focus is on compliance review and regulatory report analyses. Together, these teams will ensure appropriate oversight and awareness of the report accuracy, as well as the insights identified in our regulatory reporting process.

In addition to the above changes, our Continuous Improvement team is actively engaged to identify automation opportunities related to our regulatory report filings, which positively impacts our efficiency, accuracy, and support for report creation.

Q.15. Noncompliance reported in your bid noted data breaches through a number of your subcontractors. Please elaborate on changes you have recently made to improve in this area.

A.15.

Cybercrime has grown to become the world's third-largest economy after the US and China, according to the World Economic Forum (WEF). The threat to CareSource and our third parties continues to dominate our risk management efforts. [redacted]

Immediate Actions and Continuous Improvement

As part of all incident response efforts, we identify immediate actions to protect CareSource and our Members. We also identify any opportunities to improve our subcontractors' security posture and our overall Third-Party Risk Management Program. [redacted]

Third-Party Risk Assessment Program

CareSource's robust Third-Party Risk Assessment Program performs thorough due diligence reviews of our subcontractors based upon risk tier and classification. Our Third-Party Review team conducts security assessments before executing new subcontractor contracts, validating that necessary security and privacy controls are in place to safeguard Member data. This team is comprised of cybersecurity and risk management experts, many of whom hold certifications such as CISSP, CRISC, and CISA. The assessments they conduct involve reviewing detailed questionnaires, audit reports, certifications, incident management records, disaster recovery plans, penetration test summaries, and other supporting documentation. Additionally, we collaborate with an industry-recognized information security company to monitor our critical business associates' cybersecurity scores and address any deficiencies promptly. Our stringent contractual language and ongoing monitoring underscore our commitment to protecting Member data. In case of any identified deficiencies, third parties are held accountable for timely remediation. Our Chief Information Security Officer regularly updates our Executive Leadership team and Board of Directors on significant third-party risks.

Additionally, our Third-Party Risk Management team collaborates closely with our Information Security Incident Response team and our Privacy Officer to ensure lessons learned from any incidents are incorporated into our assessments and ongoing monitoring of third parties. This close collaboration and information sharing enables our strong response both during and after any incident involving third parties.

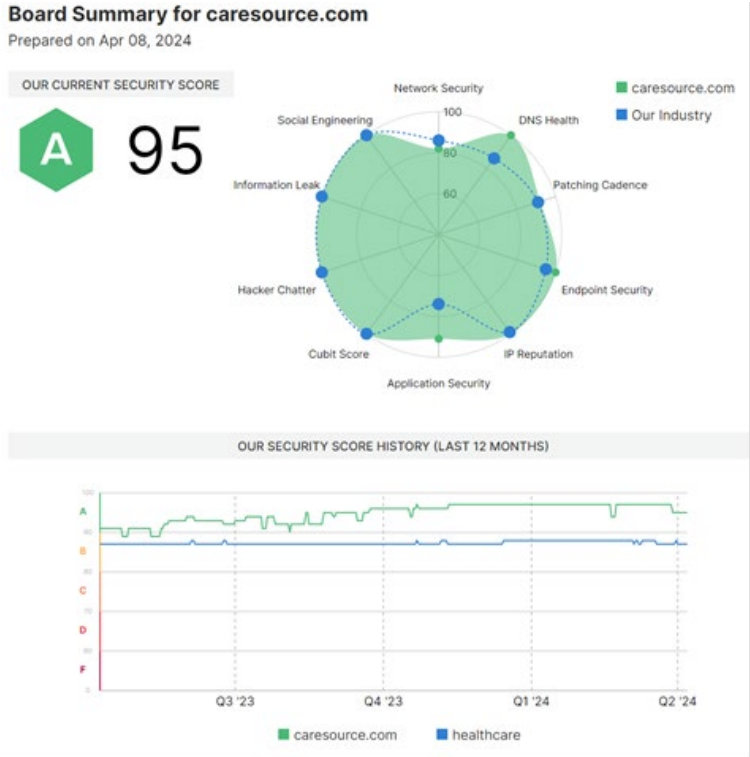
Annually, and as needed based on emerging threats, we enhance our program by refining our security questionnaires to address the evolving threat landscape. Additionally, we regularly update our security language to communicate expected minimum controls to third parties. As a member of H-ISAC, we stay informed about emerging threats and collaborate with other healthcare organizations to share best practices in third-party management. Our security monitoring service also allows us to conduct ongoing due diligence. This approach allows us to proactively engage our third-party partners to address any high-risk hygiene-related issues that we identify.

Privacy Program Incident Response

CareSource builds relationships with subcontractors who provide administrative support and assist in delivering benefits and services to our Members. We hold our subcontractors to the same privacy standards to which we hold ourselves to ensure compliance with HIPAA, HITECH, and contractual requirements. We execute a BAA with subcontractors who have access to/or maintain PHI on our behalf. The BAA requires prompt reporting of incidents, cooperation with investigations, mitigation, and remediation activities. CareSource's Privacy Officer investigates all reported incidents and provides oversight of mitigation and remediation activities to ensure root cause is addressed. Remediation activities are not limited to the specific incident. Our holistic approach to incident management reduces potential risk opportunities.

Compliance and Assessments

Our systems environment complies with the HIPAA, HITECH, and Affordable Care Acts, and we adhere to comprehensive written policies and procedures. We perform an annual HIPAA Risk Assessment, annual penetration testing, ongoing staff and subcontractor education and training, and tabletop testing of breach response and notification. CareSource's enterprise has achieved an "A" rating on our annual HIPAA Risk Assessment. We also consistently receive an "A" security rating by SecurityScorecard, shown in graphic below, which signifies that we exceed the industry average in cybersecurity practices and highlights our strong security posture.



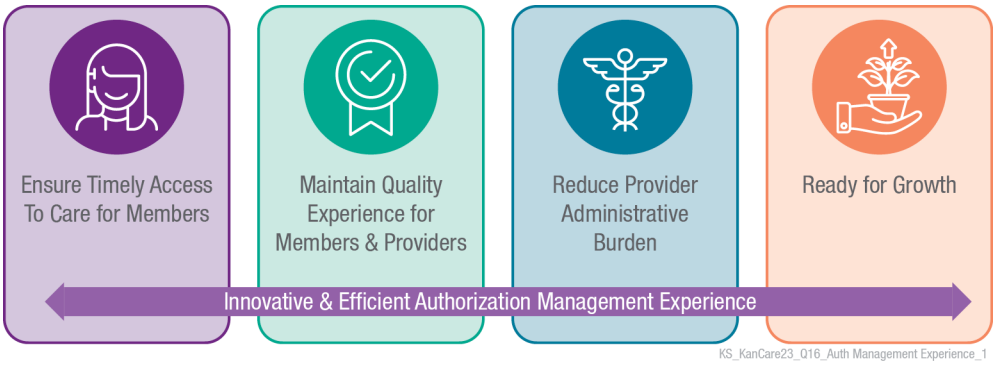
We design our information security and access management programs to keep pace with the rapidly evolving threat landscape. Our next-generation antivirus, machine learning-powered firewalls, and additional security tooling provide a scalable, defense-in-depth strategy. Additional security technologies include identity and access management, privileged identity management, multi-factor authentication, single sign-on, data loss prevention, email protection, and customer identity and access management. We limit access to PHI to those with a business need, providing specific role-based views of data and access levels that align with internal security compliance measures.

Q.16. Prior authorization difficulties are a common theme amongst Medicaid stakeholders. Please elaborate on the top 2-3 items that you are focused on related to improving the Prior Authorization Process, including changes you feel the state could make to help you achieve your goals.

A.16.

CareSource is focused on transformation of the PA process. **The heart of our success in PA transformation is our decades of experience as a trusted partner to Providers and our unique HealthAlliance perspective.** We know the administrative requirements placed on Providers first-hand and understand what matters to Providers most. Our unparalleled operational excellence encourages Provider participation by decreasing administrative burden, with a focus on transparency. **This level of collaboration and transparency has led to CareSource Providers reporting high levels of satisfaction**.

Providers must be able to focus their time on their most important role – caring for Members – so we invest in automation and technology to reduce administrative burden and streamline the PA process to support efficient and timely authorization responses.



PA Focus Areas

Our top three PA focus areas are below. We welcome the opportunity to collaborate with the State and other Medicaid stakeholders to streamline focus areas.

1. Increasing interoperability and other electronic clinical information exchange with Providers
2. Optimizing the PA process, including a 20% reduction in PA in 2024
3. Expanding our Provider Gold Carding Program

Opportunity #1: Increasing Interoperability and other Electronic Clinical Information Exchange with Providers

CareSource is a recognized leader in evidenced-based technology innovation in PA management and has been recently recognized by MCG Health (March 2024) as the recipient of the 2023 Richard L. Doyle Award for Innovation and Leadership in Healthcare. This award is evidence of our success and commitment to interoperability with our Provider partners. The catalyst of this recognition is reduction of Provider administrative burden through the implementation of MCG Cite for Collaborative Care. Via this integration, the hospital selects pertinent clinical information within the hospital EHR to share directly with CareSource. The hospital is also able to support medical necessity by selecting MCG criteria with only a

few clicks and receive an immediate approval for cases meeting designated criteria. If the authorization does not receive an immediate approval, it is reviewed by the clinical team. When complete, the decision is communicated directly back to hospital EHR making this information accessible without additional action from the user. This process enables the Provider and payer to avoid the high touch fax communication process. When implemented, this engagement results in **reduced administrative burden for the hospital and a reported savings of 20 hours per week in the authorization process.** This program is available and successful today and would be available to Kansas Providers. In addition to this integration, we also alleviate Provider burden of providing clinical information through shared access of EHRs. With this model, CareSource can utilize secure access to the EHR to obtain pertinent Member specific clinical without additional action from the Provider.

An additional challenge and a limitation in interoperability is the lack of standardization when exchanging PA information. Opportunities exist from PA forms, clinical information requirements, even the structure of electronic access via portals and EHRs. We recognize that these variances can drive inefficiencies for Providers delivering care to Kansans. In a similar market, we successfully led this change across multiple payers and created a standardized PA form for post-acute service requests. The standardized form was successfully implemented for all Providers. We are committed to leading these efforts to champion the identification of standardization opportunities across all Kansas Medicaid payers.

Opportunity #2: Optimizing the PA process including a 20% reduction in PA in 2024
PA reduction is a top priority. We are approaching this responsibility with care and intention, balancing needs of Members, Providers, and state partners. Our priority is a comprehensive process that governs the management of all PA requirements. Our approach is data and quality driven, focusing on access to covered services for Members and reduction of administrative tasks for Providers. We utilize a multidisciplinary governance model supported by our diverse PA workgroup using insight derived from our proprietary PA management tool. This tool allows us to analyze PA code performance and identify and act on market-specific trends and expectations.

In addition to data analytics, we integrate clinical and market expertise to ensure clinical quality is maintained, Member outcomes are stable, and state expectations are met. This program is on track to deliver our goal of reductions of 20% in 2024.

Driving the PA process to a higher level of efficiency is an evergreen strategy. When approaching optimization of the PA continuum, support for Providers is essential. To that end, we offer numerous ways to complete PA activities and the Provider can select what works best for their setting. Examples include:

- **Provider Portal:** We support Providers in portal adoption via education from the start. We encourage Providers to use our Provider Portal for electronic submission of authorizations and pre-service, urgent, concurrent, and retrospective request reviews. The portal serves as the central source for the coordination of all aspects of a Member's care. Providers may request authorizations and notifications for all physical and behavioral health services and medications through the Provider Portal. Providers have immediate access to view status for all submitted requests and may request updates to authorizations, including requests for continued stay review, discharge notifications, and date change requests.

  The portal further enhances the Providers' ability to obtain authorizations quickly and maintain continuity of care for Members. Our technology allows Providers to review care gaps and other HEDIS elements through proactive notifications to drive improved health outcomes for their patients. The portal is also used to upload and download Member clinical and claim information and reports in a secure and encrypted manner using industry security best practices. This information feeds into

CareSource's GuidingCare clinical platform to support collaborative, analytics-driven, person-centered approaches to care coordination, UM, and population health.

Additionally, we use feedback from Providers to clarify our PA processes when needed. For example, we recently noted a frequent error in the selection of certain fields when Providers were creating authorizations. We were able to apply point of entry guidance using WalkMe™ guidance to assist the Provider without the Provider leaving the application to review additional directions.

- **CITE AutoAuth:** To reduce the administrative burden of PA requests and PA disputes, we offer an innovative auto-authorization system, Cite AutoAuth via our Provider portal. CITE AutoAuth allows Providers to evaluate and complete MCG clinical criteria and potentially obtain an approval if criteria are met. This tool increases transparency around clinical criteria used for decision making. Over 73% of total PAs are submitted via the portal today, with 32% of those receiving a real-time approval at the time of the authorization request.

- **Direct Engagement for Complex Care Populations:** We know the PA process can be cumbersome for Members with complex care needs. Our UM team offers dedicated resources to assist with PA for this population. This team is trained in managing and evaluating clinical information across the complex landscape of chronic care. There is also direct engagement with care coordination (both plan and community-based) to escalate new care needs. For HCBS Providers, we offer an innovative portal solution to allow the Provider to submit a claim for services provided and authorized via the PCSP. Within the portal, the Provider can select the services that were completed and submit the claim to receive instant reimbursement.

- **Claims Payment Related to PA Challenges:** Our Integrated Care Operations team has dedicated resources that work to track and support PA issues to prevent delay of payment to Providers. Trends are shared with internal and delegate leaders for follow-up with HCBS CCC and Targeted Case Managers. All Providers have direct contact information for dedicated CareSource Integrated Care Operations staff. Our Integrated Care Operations team collaborates with the CCC/Targeted Case Manager and other Providers on any questions or concerns on authorizations.

Opportunity #3: Expanding our Provider Gold Carding Program

Our Provider Gold Carding Program is an opportunity to identify network Providers that demonstrate consistent, high-quality performance and outcomes and relieve PA requirements either entirely or based on performance for specific services. We have refined this opportunity and enhanced inclusion criteria for identification of Providers and oversight of performance. Some elements evaluated include quality outcomes, authorization volumes, consistency in authorization approvals. When designated as a Gold Card Provider, the PA process is eliminated, and we will monitor the Provider's performance going forward to ensure ongoing quality. Though our oversight process, we review monthly performance metrics to ensure performance remains consistent and gold carding is successful. Any concerns are addressed through a collaborative partnership approach with the goal being to improve success and prevent reinstatement of the PA requirement.

Partnering with Kansas to Achieve our PA Goals

We value the State's years of experience and believe your valuable perspectives can guide CareSource's programs and ensure transparency and accountability throughout the KanCare Program. To help us in our efforts to improve the PA process, we recommend the State consider the following efforts:

CareSource Focus Area	Recommendation to the State
Increasing interoperability and other electronic clinical information exchange with Providers	▪ Convene the MCOs in a collaborative effort that requires all MCOs to utilize standardized electronic authorization/integration options to streamline the experience for Members and ensure a consistent process for Providers
Optimizing the PA process	▪ Collaborate with the MCOs for the ongoing review of state defined PA requirements and use of a consistent hierarchy of PA requirements across MCOs ▪ Consider other billing innovations such as Episodes of Care, whereby practices receive payments based on episodes of care as the base requirement - Episodes are typically defined according to a set of diagnoses and services provided over a specified service time, especially for surgical procedures. - These models may bundle hospital, physician, and post-acute care services together. - These models allow practices to achieve higher revenue by avoiding complications, negotiating discounts, and choosing lower-cost settings for post-acute care.
Expanding our Provider Gold Carding Program	▪ Establish a common set of quality metrics for all MCOs to use, which will establish alignment between the State's goals, MCOs' responsibilities, and Provider administrative requirements to collect and report and chart the course of Gold Carding options for Providers that transgress down the continuum of VBP arrangements ▪ Create benchmarks and reports that provide current and projected trend views, ultimately supporting annual evaluations of quality metrics and goals

Healthy Blue

Additional Questions

KANCARE MEDICAID & CHIP CAPITATED MANAGED CARE
REQUEST FOR PROPOSAL (RFP)

RFP NUMBER: EVT0009267

Submission Deadline: April 10, 2024

PUBLIC VERSION

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

KanCare Medicaid & CHIP Capitated Managed Care

RFP EVT0009267

Follow up Questions for Healthy Blue:

Q.1. Can you describe your organization's strategy and preparedness to meet the diverse needs of the HCBS population, specifically addressing how you will ensure person-centered planning, promote community integration, safeguard against institutionalization, and ensure an adequate HCBS network? Please include examples of tools, resources, and partnerships you will utilize to support this population, with a focus on those members who are most difficult to serve.

A.1.

Healthy Blue's Strategy to Meet the Diverse Needs of the HCBS Population

Healthy Blue is prepared and well-positioned to meet the diverse needs of Kansas' Home- and Community-Based Services (HCBS) population. We are backed by the capabilities of our national parent company, the nation's largest Managed Care Organization (MCO) payer of Long-Term Services and Supports (LTSS) with 420,000 Members in LTSS programs and 26 years of experience. Following the best practices of our affiliate health plans with NCQA LTSS Distinction, Healthy Blue will pursue NCQA LTSS Distinction to demonstrate our commitment to meeting the diversity of Kansas' HCBS population. We operate under the core person-centered concept that individuals are more likely to do what is important ***for*** themselves (health and safety) when we understand and honor what is important ***to*** them (things that bring joy and promote quality of life).

Healthy Blue is prepared to implement a multi-pronged strategy to meet the diverse needs of individuals using HCBS, including those Members with complex health care needs (or those who experience significant barriers to accessing specialized supports and services). As characteristics of the HCBS population vary considerably by subpopulation, we will leverage tools, resources, and partnerships to ensure we continually assess needs at the population and individual Member levels to provide meaningful supports and services that meet each Member's unique needs and outcomes.

One critical component to supporting the diverse needs of the HCBS population will be delivering a bi-directional coordination platform which leads to effective teaming, strong communication, and Care Coordination with Community Care Coordination (CCC) and Targeted Case Management (TCM) entities, based on each Member's specific needs. In alignment with Appendix L of the Scope of Service requirements, Healthy Blue will overtly and purposefully integrate CCC or TCM in the processes outlined in this response. As detailed further below, ***Healthy Blue provides access to a bi-directional coordination platform, Care360, where the CCC/TCM can leverage many of our tools, allowing us to lend our expertise during the care planning process.***

Ensuring Person-Centered Planning

We recognize the individual as the expert of their own life. Acknowledging that Members' health and service needs are not static, our Care Coordination model, inclusive of our integration approach with CCC and TCM entities, is designed to adapt the level of support to the individualized needs of Members. Our

person-centered focus helps each Member craft the lifestyle they want and emphasizes their health choices, social goals and needs, dreams, desires, and meaningful experiences. Healthy Blue's person-centered planning approach for each Member begins with ensuring qualified and experienced Healthy Blue Care Coordinators (Healthy Blue CCs), Community Care Coordinators, and Targeted Case Managers who leverage assessments and tools to help each Member build their unique Person-Centered Service Plan (PCSP) or Plan of Service, depending on the Member's needs. Through our partnership with and oversight of the external entities, Healthy Blue will ensure the Member's PCSP or Plan of Service includes approaches for full access to the greater community including opportunities to seek employment and work in competitive integrated jobs, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS Waiver services. We will adhere to the State's PCSP and Plan of Service policies and support the recommended practices. Based on each Member's unique needs, the Care Coordinator will widen the circle of support and bring in additional subject matter experts, with the Member's consent, to be part of the Member's team engaged in the planning process. We will ensure robust and holistic person-centered planning by focusing on adequate staffing, thorough training for Healthy Blue CCs, conducting thorough assessments for Members and caregivers, and leveraging person-centered planning tools as described below. In addition to the resources we have available for Healthy Blue employees that make our model possible, through our approach to integration with CCC and TCM entities, we will make the same, or similar, resources available to our community partners. This will ensure their ability to provide high-quality, compliant, person-centered planning for our shared Members.

Staffing. We design our Care Coordination approach to address the varying needs of Members, recognizing those who have more complex needs may require more intensive time and support. We are prepared to maintain the appropriate level of clinical staff to ensure each Member's safety and health using factors such as:

- Acuity and complexity of the Member's clinical and Social Determinants of Health (SDOH) needs
- Language and cultural preferences
- Geography and population distribution
- Contact frequency and modalities
- Amount, scope, and duration of service needs
- Care Coordinator qualifications, experience, access to supportive staff, and proximity to the Member

Our Care Coordinator caseload ratios will allow Healthy Blue to effectively support Members with diverse needs and we are targeting a Care Coordination ratio of 1:60 for HCBS Members.

Our hiring practices are geared towards creating a diverse workforce of Healthy Blue CCs who come from various backgrounds and lived experiences, such as working in a Provider or nonprofit space or experience navigating the health care system as a recipient or caregiver. We will use a person-centered approach when identifying a good Healthy Blue CC match to include background, expertise, and proximity to the Member. [redacted]

[redacted]

Care Coordinators, from Healthy Blue and within the community, are supported by a comprehensive interdisciplinary team, inclusive of Providers, which is positioned to support the Care Coordinator in addressing the unique needs of each Member — whether it be a complex medical need, a behavioral support need, or a social need. The interdisciplinary team may extend to other community-based organization (CBO) professionals. The Care Coordinator will work closely with all Provider types,

including HCBS Providers, to gain their perspective on the types of support each Member needs and contribute to the ongoing plan to support the Member.

Qualified and Highly Skilled Care Coordinators. To ensure our Healthy Blue CC team facilitates integrated care for Members, we will cross-train them to recognize and address whole-person needs. We provide specialized training for all staff through our dedicated LTSS Training team and LTSS Training platform, which offers a combination of self-paced and live trainings that cover specialized topics. These trainings incorporate evidence-based, best practice programs to facilitate the delivery of whole-person care, trauma-informed care, mental health first aid, recovery and resiliency, behavioral modification, and motivational interviewing. This training includes awareness of the unique needs of each of the waiver populations: PD, BI, FE, IDD, SED, TA, and AU. As part of our offering, and in alignment with our approach to integration with CCC and TCM, these trainings will be made available and offered to our community partners providing support to our shared Members. CCC and TCM entities will have full access to our suite of trainings, as well as technical assistance and support as needed or desired to ensure they are supporting Members in alignment with our person-centered coordination model.

Required training for Healthy Blue CCs also includes [redacted]

We have certified PCT trainers in positions of leadership which helps us ensure a person-centered approach is foundational to everything we do. Person-centered thinking tools provide practical strategies for gathering meaningful information and facilitating conversations about goal setting, problem solving, and action planning. This approach provides a framework for building effective relationships and opens the door to greater collaboration and planning in partnership. All Care Coordinators will take regular refresher courses that include a knowledge check to confirm they remain up to date with our PCT practices.

Our training shifts the traditional model of care delivery from leading coordination activities for Members to working with them to establish their own goals and make decisions that improve their overall health and quality of life. Healthy Blue CCs complete trainings such as those seen in Table 1-1.

[redacted]

Care Coordinator Training		
General LTSS	**HCBS and Kansas Specific**	**Person-Centered**
Nursing Facility Transitions	TCM and CCC Roles and Responsibilities	Cultural Competence in Health Care
Employment First		Caregiver Stress and Burnout
Motivational Interviewing		Charting the LifeCourse

Using person-centered thinking and planning skills, coupled with HCBS and LTSS knowledge, our Healthy Blue CCs will be well equipped to oversee and approve PCSPs and Plans of Service created by the Member and the CCC or TCM, ensuring the Members' desired outcomes within a framework of how that person wants to be supported to achieve their goals is clearly documented. Through their oversight, the Healthy Blue CC, in cooperation with the training tools and resources available through Healthy Blue, will be poised to support the Community Care Coordinators and Targeted Case Managers in engaging in quality person-centered planning.

Assessments. Healthy Blue Care Coordination activity starts with getting to know the Member and understanding what is important ***to*** and ***for*** them and ***how*** they want to be supported. At Healthy Blue, we leverage motivational interviewing to help individuals discover their own interest in considering and making a change in their life. motivational interviewing can be highly effective to understand and evaluate the unique needs of older adults and individuals with disabilities. We will use all available information and follow a comprehensive assessment process to effectively understand and meet the unique needs of Members receiving HCBS services. ***Our Indiana affiliate health plan's outstanding assessment tool was chosen over all other MCOs as the template for the State's Indiana PathWays program.*** We also hold a license and have experience leveraging the interRAI assessment tool comprehensive assessment and stratification capabilities. Should the State choose this tool, we can quickly adhere to the State's requirements for assessments.

As part of the assessment process and the Healthy Blue CC's subsequent regular contact with their assigned Members, they will monitor for potential eligibility for HCBS Waiver programs or transition to or from Adult Care Homes. If indicated by assessments or clinical judgment, the Healthy Blue CC will refer the Member to the appropriate assessing entities to determine functional eligibility within two Business Days. We will follow up with the referred entity based on the relevant HCBS Waiver requirement to verify the entity has scheduled or completed the functional assessment.

The goal of Member assessments is to identify and address various aspects of a Member's overall health, well-being, and identify their self-identified quality-of-life goals. This assessment process includes addressing:

- **Preferences and Goals.** Employing a person-centered approach to effectively capture each Member's desired outcomes and preferences for how to best support achievement of their goals.
- **Health Status.** Assessing medical history, diagnosis, current health status, medication usage, and treatments.
- **Functional Status.** Assessing the Member's ability to perform daily activities (like eating, dressing, personal hygiene, and mobility) and instrumental activities (like managing medications, cooking, cleaning, transportation, and managing finances).
- **Mental Health Status.** Identifying any cognitive or mental health needs, such as dementia, depression, or anxiety.
- **Sensory Status.** Checking vision, hearing, and affected sensory capabilities.
- **Social Support and Environment.** Understanding support systems, such as family members, caregivers, community resources, and living environment.
- **Employment or Volunteering**. Understanding and supporting interests in employment or volunteering in their community.
- **Nutritional Status.** Evaluating dietary habits, nutritional intake, and any specific dietary needs or concerns.
- **Risk Factors.** Identifying potential risks, such as falls, isolation, neglect, abuse, or potential for hospitalization.

- **Eligibility for Assistance.** Assessing eligibility for aid, depending on the financial situation and available resources.
- **Service Needs.** Identifying which services, therapies, social programs, or adaptive equipment would best meet their needs.
- [redacted]

Our comprehensive assessment takes several aspects of each Member's life into account by considering what has and has not worked for them in the past and how they are best motivated towards health behaviors, allowing for a more personalized and effective PCSP or Plan of Service. It also allows for identification of populations at greater risk for negative health outcomes and complex care needs. This is critical in proactively seeking out Member-specific supports during the PCSP and Plan of Service development process.

Upon completion of the assessments, Care Coordinators document a conclusion about the information's meaning or its implications for the Member's situation. They will review and incorporate assessment results into the PCSP or Plan of Service.

Whole-Person Care Planning Tools and Approach. Through the assessment and person-centered planning process, we focus on Member choice, preferences, and strengths. Our approach in facilitating the development of and/or approving the PCSP and Plan of Service includes questions to guide the discussion to promote choice, self-determination, and risk mitigation by identifying barriers and planning for potential adverse events. When the PCSP is driven by the TCM or CCC, the Healthy Blue CC will contribute to the PCSP development as an actively engaged Interdisciplinary Care Team (ICT) participant and approve it once completed.

We support the State's efforts to expand implementation of Charting the LifeCourse (CtLC) to improve person-centered planning for individuals and supporting families in the Medicaid program. Our affiliates have been using this framework to enhance person-centered planning since 2020, and we will leverage our existing CtLC Ambassadors (more than 30 nationally) to train our Kansas Healthy Blue Care Coordinators in the key principles and establish Kansas CtLC Ambassadors.

[redacted]

Based on each Member's needs, goals, and preferences, we will follow the appropriate Care Coordination Level and incorporate Providers, services, external supports, natural supports, and community resources into their PCSP or Plan of Service. In building a Member's PCSP or Plan of Service, the primary Care Coordinator will support the Member and work closely with their care team as the Member identifies their strengths and goals toward their health, well-being, and independence. The care team will help them establish steps to achieve and maintain community integration and independence which may include elements such as competitive integrated employment, implementing home supports and technologies, and social supports. The process includes building backup and disaster preparedness plans to ensure continuity of support and living environment. The person-centered planning process is always Member-driven. Our holistic, person-centered approach supports informed choice for all Members with HCBS, regardless of the complexity of their needs, and ensures service delivery in the most integrated setting of their choice. Being certified in Person Centered Thinking and trained in using CtLC concepts, our Care Coordinators will identify each Member's unique needs, preferences, and priorities to help them achieve their desired goals and outcomes while promoting health and quality of life.

Promoting Community Integration

We will assist Members in fostering their well-being and maximizing their daily independence by promoting an inclusive living environment. We will employ risk identification and mitigation strategies for every Member living in the community to guard against factors that could result in declining health and their ability to continue to live in the community setting of their choice. We will provide supports and approaches to promote community integration through the following tools, resources, and partnerships.

Integrated Care Coordination. To support a seamless Member experience as they transition to the community, we integrate a Member's physical health, Behavioral Health (BH), and LTSS along with innovative programs and supports — all based on their needs, preferences, and self-identified goals. We will streamline Member communication and centrally store Member information, so they feel supported but not overburdened. [redacted]

We take a proactive approach to assure each Member's successful community integration by establishing check-ins and monitoring and working closely within our organization and with external stakeholders such as the Member's care team, facilities, and CBOs. Depending on their specific situation, we will reach out to the Member per established time frames in the care plan, and more frequently if needed, providing outreach in alignment with their Care Coordination Level. This includes emphasis on strong collaboration and effective communication with any CCC or TCM who is supporting the Member.

Disease Management. We will support Members to prevent and control the progression of chronic conditions. Through assessment and treatment plans we focus on prevention and monitoring, encouraging Members to take proactive steps to managing their health such as vaccinations and screenings. We will also educate Members on warning signs and triggers and emphasize the value of medication adherence to manage their conditions successfully. [redacted]. Person-centered, self-management plans are part of the PCSP or Plan of Service and guide and support Members in their health care journey. Providing support for physical, mental, and emotional well-being encourages a Member to take a leading role in developing the PCSP and following through with goals and interventions. We address many psychosocial issues that may be impacting the Member's ability to follow their treatment plan and access needed supports.

Transition, Discharge, and Backup Planning. Prior to a discharge as applicable, a Healthy Blue Transition Specialist and Care Coordinator will review the Member's discharge plan and action items to ensure all elements of the transition plan are being executed. Transition planning includes activities before, during, and after the transition that support the Member's success in the community including paid and non-paid supports, plans for community integration, connection with physicians and specialists post-discharge, and steps for maintaining or growing meaningful relationships. The Member's PCSP or Plan of Service includes a relationship mapping exercise that helps them identify individuals in their life who could be available for social and backup support in case of a crisis or emergency. We ensure those individuals are in place for backup and safety supports. As Members transition back into the community there may be the need to have more paid supports on the front end with a plan to fade those supports as the Member becomes more acclimated to their community.

Modifications and Assistive and Enabling Technologies. [redacted]

[redacted]

Natural Supports and Relationships. Through our CtLC program and in alignment with their PCSP or Plan of Service, Care Coordinators will support Members in identifying their natural supports and development of relationships in their community. We will help Members maximize a rich community life by fostering relationships and connections. We recently partnered with The Arc of Douglas County and Self-Advocates Coalition of Kansas (SACK) to provide training for Peer Supporters with IDD toward serving as supports for individuals to build social, community and employment relationships. We also supported Three Rivers Inc. Independent Living Center to offer Healthy Community Living Training, an evidence-based physical fitness and healthy lifestyle program that supports individuals in maintaining their mobility and well-being in the community.

[redacted]

Employment Opportunities and Support. Employment is often critical to community integration and has a direct relationship to positive health outcomes. During person-centered planning, we will identify Members interested in employment and explore employment options. We will evaluate needed supports and services will be evaluated, including waiver and non-waiver services, and available vocational rehabilitative services as appropriate. During the process, we will outline their employment goals, risks, and barriers to plan for successful employment will be outlined. We will meet Members where they are, recognizing the diverse needs of the populations we support and use the most appropriate supports leveraging the STEP Program, and the WORK program for already working individuals, tapping into HCBS Waiver employment services when Members need job development, job coaching, or skills training. Each Member is unique; therefore, we map out the steps to help them achieve their personal goals including services that best suits their preferences and needs.

[redacted]

[redacted]

Comprehensive Caregiver Strategy. A critical risk to successful community living or transition can involve caregiver fatigue, stress, and health. This is particularly true for caregivers of Members with an IDD or BH condition as these Members often require the most complex services. To support caregivers, where applicable, our Member Advocates will offer assessments and coordination of resources and supports for the caregiver. [redacted]

Safeguarding Against Institutionalization

Healthy Blue recognizes institutional care of anyone has significant negative outcomes for all individuals. It reduces their ability to fully experience self-determination and engage in integrated community life. Community- and home-based residential settings and services are more cost-effective than institutional settings and enhance a Member's ability to remain independent and achieve their goals. Through the person-centered planning process, our Care Coordinators will work closely with the Member and their designated care team and CCC/TCM to develop a PCSP or Plan of Service that is sustainable and addresses their evolving physical, behavioral, and LTSS needs to divert from institutionalization. We employ approaches to identify Member risk and reduce it through tools, resources, and partnerships such as those described below.

Sustainable Person-Centered Planning. As highlighted earlier, effective person-centered planning process focuses on ensuring full access to the greater community. We will seek to sustain the current support needed and anticipate risks and the likelihood of a change in circumstances. We will engage with and monitor the Member working with the CCC/TCM updating their PCSP or Plan of Service, as needed, and bring in services and supports to keep them successfully living in their home of choice.

Data Analytics and Our LTSS Outcomes Measures Dashboard. Through regular contact with Members, continuous monitoring, and predictive analytics, our Care Coordination team will identify Members who may be at risk for admission to a facility. We will identify Members with IDD and BH conditions to ensure they receive the right level of Care Coordination and support. We will monitor Members' complex medical conditions, emergency department (ED) and inpatient admissions, changes in functional capabilities or caregiver supports. We enhance Care Coordination and management, so Members can safely remain in their preferred home environment. [redacted]

[redacted]

Integrated Rounds. Daily integrated rounds will be led by one of our Medical Directors and focus on those Members who are most difficult to serve – such as those with complex medical needs, or those with a limited history of encounters despite significant chronic conditions. Integrated rounds will provide the opportunity for Care Coordinators to consult regarding care for Members with specialized, complex, comorbid, or co-occurring conditions. The collaborative approach provides the team with an opportunity to develop innovative strategies to identify a path to support the Member and remove barriers to care. The Care Coordination team will work collaboratively with the inpatient team, treating physicians, social workers, and community health workers/community health representatives to proactively ensure Members have access to the services they need. Our Care Coordination teams and clinical leadership will welcome Providers and facilities to participate as appropriate in integrated BH and physical health rounds as necessary to discuss challenges, barriers, and support needs to successfully transition Member care. Integrated rounds also provide an opportunity to focus on Members with the highest trending readmissions who have returned to inpatient care and help prepare supports for Members and their caregivers before they discharge for a successful transition.

Training. As noted above, having a properly trained and prepared Care Coordination team is of critical importance to support Members with complex needs. We will provide training, as seen in Table 1-2, so Care Coordinators are knowledgeable of all the levels and intensity of care available within the KanCare network and community, which will enable them to work collaboratively and continuously to match support to need. With a strong workforce providing supports to Members, they are equipped to help Members avoid institutionalization. With Care Coordinator evaluation and quarterly PCSP and Plan of Service audits, we will further train Care Coordinators should their aggregate score fall below 90%.

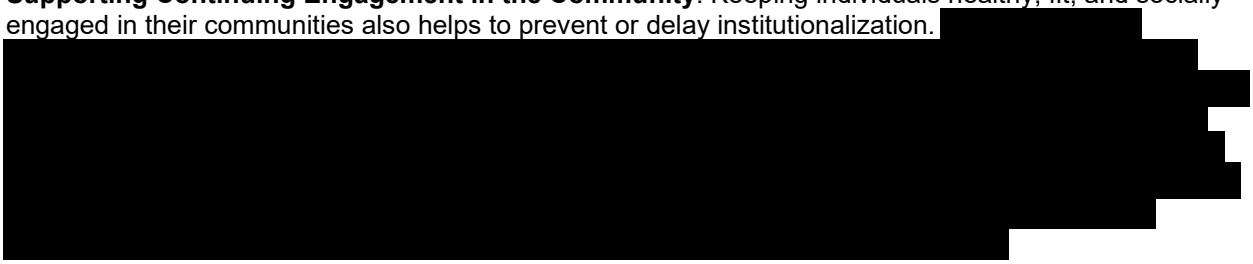
Transitions from Inpatient and ER Settings. Successful transitions can be a critical factor in helping Members avoid higher levels of care and institutionalization. This is particularly true for Members with IDD and Members receiving LTSS services. These populations require time-sensitive engagement and intensive cross system coordination. Our Care Coordinators will initiate discharge planning upon inpatient admission for Members, including those admitted into inpatient level of care presenting with complex BH or non-medical risk factors to establish appropriate communications needed to plan transitions, follow-up care, and supports. We will work with discharge planners to develop a comprehensive discharge plan that considers all the Member's medical, behavioral, and social support risks that might lead to a readmission and work collaboratively with the family and caregivers to secure informal natural and community supports. This includes crisis and safety planning. Because Members may not have stable housing, our Care Coordinators will work with the Member, inpatient facility, Housing Stability team, or other external case managers or agencies supporting the Member to ensure the Member has an appropriate post-discharge living arrangement. During the Member's acute care stay, our Care Coordinators will connect with the Member's PCP, and other needed community Providers as applicable to collaborate on an integrated cross functional plan to comprehensively assess the supports necessary for the Member to transition and maintain a community-based setting. The Member's Care Coordinator will follow up within 48 hours of discharge to ensure post-discharge services are effective, so the Member has what they need to be successful with their transition home and avoid another ER, inpatient stay, or institutionalization.

Transition from Nursing Facilities. Successfully moving Members from institutional settings is another component to safeguard against extended stays. The process of identifying Members who have a desire or ability to transition is ongoing and proactive. Each facility will have a dedicated assigned Care Coordinator who is responsible for monitoring and advocating on behalf of any Member in that facility who has expressed a desire to go home. In addition to facilitating transition referrals from facility staff, the Care Coordinator will have regular conversations with each Member to monitor their mindset around transitioning out of the nursing facility while also discussing the barriers and providing options to address those barriers such as housing, skilled care, therapies, home modifications, caregiver availability and support and Providers. The Care Coordinator will closely review the Minimum Data Set (MDS) and supporting records to find information that would support the transition.

If the Member decides to proceed with the transition to home-based care, the Care Coordinator begins with the appropriate assessments and evaluates the Member's care needs and barriers to a successful transition, as described above. We will work with discharge planners to make sure all medical, behavioral, and social supports are in place prior to discharge and work collaboratively with the family and caregivers for a successful transition to a home-based setting.

HCBS Provider Partnerships. HCBS Providers play a critical role in avoiding institutionalization for the HCBS population. Our Healthy Blue Care Coordination team and LTSS Provider Relations team will prioritize frequent engagement with Providers to evaluate the efficacy of services and gain insight from the Providers' experience supporting Members. Care Coordinators will engage the Member's care team at intervals determined in their PCSP or Service Plan and as needed Stakeholders can access Member information in a centralized location to promote communication and awareness among Providers.

Supporting Continuing Engagement in the Community. Keeping individuals healthy, fit, and socially engaged in their communities also helps to prevent or delay institutionalization.



Ensuring HCBS Network Adequacy

Healthy Blue will use our proven network development strategy to make sure our LTSS and HCBS network is comprehensive, with Providers educated and supported to meet the complex, ever-evolving needs of Members receiving LTSS. Our network design strategy is to exceed adequacy requirements and provide all Members with ample choice of high-quality Providers to help meet their needs, where they reside. Further, we make sure Providers are positioned to meet the specific support needs and self-identified, person-centered goals of Members in a high-quality and timely manner.

While we are prepared to implement many strategies and protocols to mitigate service gaps and provide continuous needed care, we acknowledge that unforeseen circumstances may cause a delay or gap in providing services. In these situations, we will take immediate action to make sure the Member not only receives the care they need but receives it in the way in which they prefer. This includes using an emergency resource as part of their backup plan or receiving care from a trained and qualified self-directed worker. The Care Coordinator will send another automated referral to identify a backup Provider and remain in contact with the Member until their health and safety are fully addressed through whatever means are necessary. If a specific service is not immediately available, our Care Coordination team will work with our Specialty Provider Relations team to expedite onboarding of new Providers or identify alternatives to meet the Member's needs.

As a crucial component of Members' PCSPs or Plans of Service, we emphasize the significance of a robust emergency backup strategy to identify and proactively plan for how to address potential service gaps, particularly those that might arise from unforeseen challenges with direct care workers. Recognizing the vital role of relationships and community support systems, we identify natural supports,

community allies, and other relationships that can be fortified and leveraged as backup resources during service disruptions. Prior to integrating them into the backup plan, we will obtain Members' explicit approval and commitment. Then, we will conduct comprehensive training sessions to familiarize these supports with the Member's specific services and care requirements. By taking these proactive measures, Members will feel prepared when gaps in care occur and know about the resources available to make sure they receive care when needed.

Leveraging Tools, Resources, and Partnerships

Healthy Blue understands the value that tools, resources, and partnerships play in understanding Member needs and optimizing resources for the HCBS population. In addition to those described above, a sampling of tools, resources, and partnerships is outlined in Table 1-2.

Table 1-2. Healthy Blue leverages tools, resources, and partnerships for supporting HCBS Populations

Additional Tools, Resources, and Partnerships for Supporting HCBS Population	
Tool	**Description**
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Charting the LifeCourse	The CtLC framework was created to help individuals and families of all abilities and all ages develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. CtLC includes tools that address 12 different domains important to human growth and development. It builds upon the Learning Community's Person-Centered Thinking skills, providing an array of tools and resources so that individuals can use to plan for their own life.
[redacted]	[redacted]
interRAI Assessment Tool	We have a license for the interRai Assessment tool, and it is used by affiliate health plans in states where it may be required. We are prepared to implement this tool should the State choose to use it. The assessment identifies key factors in the person's life, including function, health, social support, service use, mood, and behavior. It collects information needed to support decisions about care urgency, need for more comprehensive assessment, a person's quality of life, and referrals to other services and supports.

Additional Tools, Resources, and Partnerships for Supporting HCBS Population	
[redacted]	[redacted]
Resource	**Description**
Interdisciplinary Team	Healthy Blue CCs are supported with resources from all departments including Whole Health, Member and Provider Services, Clinical Care teams, Quality Management, Community Engagement, Utilization Management (UM), Program Integrity, Pharmacy, and Claims.
LTSS Center of Excellence	Our National LTSS COE, brings together our organization's LTSS leaders from affiliate health plans and national Specialty Products teams across the country to discuss and share best practices and innovations. The COE helps identify and facilitate the implementation of best-in-class strategic and operational solutions, systems capabilities, and consistent policies and procedures to achieve program integrity and excellence among our LTSS programs.
Partnerships	**Description**
The Arc of Douglas County and SACK	Healthy Blue funded a peer support training for individuals with IDD that will be established in collaboration with SACK. Trained Peers will be able to support other individuals with IDD to develop community engagements like social connections and employment.
Center for Independent Living (CIL)	We partner with CILs to deliver Healthy Community Living Training to develop self-management, mobility, and healthy eating practices in Members. We will also engage with CILs to provide Community Navigators. Community Navigators, peers with lived experience, support Members who need assistance in the community in addition to what Care Coordination provides.
MapHabit	MapHabit is a Healthy Blue partner that helps Members live successfully in a home-based setting. MapHabit uses a patented visual mapping system supported by smart devices to improve cognition and reinforce routine habits in individuals requiring neurocognitive support. MapHabit is a neuroscience-based interactive Member engagement platform. IDD is one of several established indications for MapHabit, which personalizes content to support Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) independence and quality of life.

Ongoing Process Improvements in Person-Centered Planning

Healthy Blue's whole health Care Coordination program is supported with a strong architecture of tools, resources, and partnerships. Routine feedback cycles will inform continuous quality improvement to adapt programs for Members and systems of care with evolving needs while assuring we meet compliance requirements and deliver the highest quality services and supports to Members. Our holistic approach includes monitoring Care Coordination performance, tracking Member outcomes, and gauging Member satisfaction. We also gather input from NCQA, our Medical Advisory Committee, KDHE, KDADS, and other stakeholders to assess the effectiveness of programs. We continuously analyze data such as SDOH needs, diagnoses, claims, and pharmacy data to identify HEDIS care and medication gaps, under- and over-utilization, and avoidable events.

We will document quality improvement processes in our Quality Management Program Description and Work Plan. We apply rapid cycle Continuous Quality Improvement processes such as Plan, Do, Study, Act cycles and Lean Six Sigma principles to enhance our processes, providing a variety of performance improvement tools such as cause-and-effect diagrams and control charts, to drive lasting change. A dedicated audit team will complete a quarterly audit of a random sample of 25% of PCSPs or Plans of Service and Needs Assessments from Healthy Blue CCs and external entities. Based on the results of the review, Care Coordination supervisors may provide additional individual or group training. If a Care Coordinator's aggregate score is below 90%, the supervisor will develop a corrective action plan to address

specific deficiencies. Healthy Blue is well prepared to meet the diverse needs of the HCBS population and will continue to refine our approach as needed to ensure we meet each Member's unique needs.

Healthy Blue is positioned to implement the multi-pronged strategy outlined in this response to meet the diverse needs of individuals using HCBS. Our strategies leverage the tools, resources, and partnerships that we have built and allow us to refine our approach, as needed, to ensure we meet each Member's unique needs. Our commitment to effective person-centered planning and bi-directional Care Coordination will ensure that we execute on our strategy and achieve KanCare's vision of collaboration and partnership to realize optimal health outcomes for Members.

Q.2. How will your organization ensure and promote compliance with the HCBS Final Settings Rule, ensuring that all settings where HCBS are provided meet the criteria for being integrated in and support full access to the greater community? Please detail the process for evaluating current settings, implementing, and supporting necessary modifications where warranted, and monitoring ongoing compliance with the rule.

A.2.

Ensuring and Promoting Compliance with the HCBS Final Settings Rule

Our organization is regarded as a leader in supporting Providers and Medicaid agencies within our 10 affiliate state health plans where we operate Long-Term Services and Supports (LTSS) Programs when it comes to supporting the implementation and maintenance of the Home- and Community-Based Services (HCBS) Final Settings Rule. This support includes Tennessee, which is the first state to receive transition plan approval. We will apply our knowledge, experience, and best practices to promote and ensure compliance with the HCBS Final Settings Rule, making sure that our contracted Providers deliver quality services that respect Member choice and their rights to autonomy and community integration.

Experience Supporting Implementation of the HCBS Final Settings Rule

Through our ***LTSS Center of Excellence***, comprised of varying backgrounds, such as former state LTSS and Intellectual and Developmental Disability (IDD) Directors, Waiver Managers, and leaders from both large and small LTSS Providers, our organization has an array of experience supporting the implementation and compliance with the HCBS Settings Rule. We have worked directly with state Medicaid agencies to outline and execute the process for conducting assessments, supported Provider reviews and remediations in the heightened scrutiny process, and led efforts to monitor ongoing compliance, ensuring specialized staff dedicated to compliance monitoring. Specific examples of how our affiliates have supported states with implementation of the HCBS Settings Rule include:

Promoting Compliance

Promoting network compliance with the HCBS Final Settings Rule is a key priority for Healthy Blue. We will ensure Members have full access to the benefits of community living and the option to receive services in the most integrated setting. Recognizing the critical importance of this transformational Rule, Healthy Blue will promote compliance as approved and in alignment with the Kansas Department of

Aging and Disability Services (KDADS) and their Final Rule Team through the following processes, as described in our response:

- Implementing administrative best practices based on lessons learned from our affiliate health plans
- Evaluating compliance with current settings as part of joining and remaining in our Provider network
- Conducting initial and ongoing Staff and Provider training
- Embedded HCBS Settings Rule experts within our internal teams
- Applying person-centered planning practices as the cornerstone of our Care Coordination model

Administrative Best Practices

As approved by KDADS, Healthy Blue will bring the following best practices and lessons learned from affiliate markets to support KDADS and Providers in achieving and maintaining compliance with the HCBS Settings Rule:

- Ongoing meetings with KDADS and other Leaders to discuss processes in place, barriers, and best practices.
- Facilitating Joint Operating Committee meetings with Providers who are struggling to attain or maintain compliance to identify opportunities for technical assistance or evaluate resources to support compliance.
- Partnering with MCO partners to align approaches for ongoing evaluation of Providers to reduce administrative burden for Providers who are contracted with more than one MCO.

In alignment with the KDADS TRAIN program, we are developing Provider resources, such as Provider Training, Manuals, Policies, and Quick Reference Guides to support Provider-facing education, accessible through our Provider websites. We are:

- Complying with state requirements in our Provider Training program to include robust Person-Centered Thinking© (PCT) training sessions made available in-person or virtually and web-based education to allow Providers to self-select training modules to support ongoing training compliance.
- Designing global workflows to facilitate communication pathways between Care Coordination, Provider Relations, and the state to keep alignment on the status of Provider settings
- Developing market-specific policies and procedures for HCBS Settings Rule compliance visits, implementation and monitoring of remediation plans, and Provider termination for non-compliance.
- [redacted]

Evaluating Current Settings

Healthy Blue recognizes that one of its most valuable resources is the development of an adequate and accessible Provider network that is ready to meet the individualized needs of the population served and is critical to complying with and promoting the HCBS Settings Rule. To ensure we can support these specialized Provider types in ongoing compliance, Healthy Blue will have a dedicated LTSS Provider Relations team who are responsible for building and maintaining our LTSS network. We will ensure our dedicated local LTSS Provider Relations team fully understands the unique challenges and expectations of these Providers and with the HCBS Settings Rule. The Provider Relations team members, with backgrounds in areas such as LTSS service provision, claims, PCT, and workforce development, will use a high-touch approach to building long-standing relationships and develop, expand, and enhance our network's compliance with state and federal requirements, including the HCBS Settings Rule.

When a Provider applies to our network, our LTSS Network Development and Provider Relations teams will collaborate to confirm that Providers meet the appropriate qualifications and have the capacity to deliver what they have applied to provide, including verification of the HCBS Settings Rule. We will do this through Provider credentialing processes and associated on-site visits. Additionally, our contracts include value-based purchasing (VBP) models that promote the delivery of high-quality, person-centered care in the most integrated setting to further encourage increased quality within their organizations.

Credentialing. Our Network Development and Provider Relations teams collaborate to review criteria when bringing a Provider into the network and when assessing the performance and quality of our existing network. Examples of Provider Qualifications we assess during contracting and credentialing include:

- HCBS Settings Rule compliance. This will be verified as defined by the state and associated KDADS Final Rule Compliance Certifications.
- Experience in supporting older adults and individuals with IDD in meeting their self-identified goals and promoting independence and community engagement, including the development of relationships with key community resources, which may enhance the Member's experience and progress toward meeting their goals.
- Recognition of Providers who have shown initiative in enhancing their skills, such as investing in PCT training or acquiring recognition like the Council on Quality and Leadership.
- Policies and processes to support staffing recruitment and retention to support the timely delivery of high-quality services and continuity of assigned staff.
- Ability to support Member communication needs and preferences, such as staff who are competent in languages other than English, proficient in engaging with individuals who do not communicate using spoken words, and confident in leveraging technology to promote effective communication.
- Experience supporting diversions from higher levels of care and transitions between care settings.
- Compliant with using the Electronic Visit Verification (EVV) system to track service provision and leveraging that system to share key updates on instances in which the Member may have experienced a change in circumstances that requires a Care Coordination intervention.

Onsite Reviews. As mentioned here, with approval and in alignment with the KDADS Final Rule team's compliance assessment and certifications, our Provider Relations team would conduct a site visit, utilizing a dedicated tool, as part of their coming into and continuing within our Provider network. This would be used to verify information, such as demographics, capacity, performance, and quality, as well as to verify ongoing Provider compliance with the HCBS Settings Rule. This visit and tool are tailored specifically to LTSS Providers, which could include an HCBS Settings Assessment component. If approved by the state, the following are some key provisions of the HCBS Settings Rule we could review onsite to ensure the Provider remains in compliance:

- Assessing the physical location and living arrangements and ensuring the location of service provision is integrated into and support the Member's full access to the greater community.
- Assessing supporting documentation, such as proof that paid and unpaid staff receive new hire training and continuing education related to residents' rights and member experience as outlined in HCBS rules.
- Reviewing Provider policies and procedures, ensuring they outline residents' rights and member experience made available to residents.
- Conducting Member/staff interviews to ensure the policy is implemented and enforced around privacy, residents' rights, understanding of leases, and choice in living arrangements, activities, and community integration.

In addition to complying with the provisions above, Providers must demonstrate that they do not provide services in a setting that has qualities of an institution, such as being co-located on the grounds of an institution. Based on the review, we will develop a remediation plan for the Provider that addresses any areas of noncompliance, outlining the remediation necessary and a timeline for compliance.

As a best practice to further support our compliance with the HCBS Settings Rule, we will use [redacted]

Upon the Provider's network approval, which follows verification of their HCBS Final Settings Rule compliance and Provider qualifications, we add Providers to our Find Care Provider Directory, which will identify associated recognitions or expertise, such as physical accessibility and expertise, with alternative means of communication (picture boards, sign language, assistive technology). This process serves as a check and balance for Care Coordinators and Members to ensure that we have confirmed the Provider delivers accessible services in the most integrated setting and provides choice and visibility of who they want to deliver.

Value-Based Purchasing Models. We will combine our organization's existing and extensive VBP experience in Kansas with our national industry-leading Medicaid VBP experience to shift Kansas Providers into arrangements that support service quality, value, and outcomes. For example, we will offer an [redacted]. Ultimately, our goal is to support Providers in creating environments that promote independence, choice, and inclusion for all members.

Staff and Provider Training

We will implement internal staff and external Provider training programs to ensure they are informed, understand, and comply with the HCBS Settings Rule. The trainings will be designed to complement and align with state requirements and TRAIN program and learning collaboratives. Training will include HCBS Setting Rule topics such as HCBS Settings Rule Basics, your role and responsibility, ongoing monitoring, and robust PCT sessions made available in-person or virtually.

Staff Training. We will train our Care Coordination, delegated Community Care Coordination (CCC)/Targeted Case Management (TCM), and Provider Relations teams during onboarding and annually to ensure we expand the number of HCBS Settings subject matter experts who are embedded in each department. This enables our teams to quickly identify and assess whether Providers meet compliance with the Rule and ensure that the member's experience aligns.

[redacted]

Provider Training. In addition to the site visits mentioned here, we will employ an LTSS Provider Training Specialist, who will be responsible for knowing the KDADS TRAIN program and the training and collaboratives offered and supporting the state in those efforts as deemed appropriate. This individual will also be responsible for continually enhancing and overseeing a comprehensive initial and ongoing Provider Training and Communication Plan and associated trainings and resources, inclusive of a focus on the HCBS Settings Rule, as well promote and track to Provider attendance, understanding and satisfaction of the content and delivery methods.

To further support and drive Providers' and DSPs' increased quality and development in alignment with the HCBS Settings Rule and Person-Centered Planning, we have [redacted]

- A PCT training track for Providers and their staff to ensure the foundational mindset is set throughout their organization, ensuring those who support can deliver services that are consistent with person-centered practices. While our own internal LTSS staff are trained in-house by our LTSS Training team, we wanted to extend that offer to the Provider networks as well.
  - This will be a hybrid Provider-facing eLearning Course that includes the traditional eLearn self-paced format, followed by a live, virtual one-day, six-hour training with IntellectAbility trainers before becoming PCT certified. These courses include Core Concepts, Learning Log, Working/Not Working, Donut Sort, and 4+1 Questions.

- Unlimited offerings of training to DSPs that will provide education for professional development and recognition unique to their profession. Together, we identified five eLearnings that will earn them the "IntellectAbility recognized health supporter for people with IDD" Badge. These courses include: The Fatal Five, Person-Centered Thinking, A Guide to Manage Choking, Physical and Nutritional Supports, and Actions Speak Louder Than Words, which essentially teach how to recognize common behavioral presentations of commonly seen medical conditions in people with IDD.
  - Additionally, these courses have been approved by the National Association of Direct Support Professionals (NADSP). The courses will count toward their badging system, allowing learners to earn multiple credentials through their completion.

Person-Centered Planning

The person-centered planning components of the HCBS Settings Final Rule prioritize choice and autonomy, which are foundational principles of our Healthy Blue Care Coordination strategy. With the support of our national LTSS Center of Excellence, Healthy Blue will ensure that all policies, procedures, and tools leveraged in the person-centered planning process are fully compliant with the HCBS Final Settings Rule, specifically focused on alignment with all person-centered thinking criteria and ensuring that no HCBS settings possess characteristics of an institution.

We train our Care Coordinators, including the Targeted Case Manager or Community Care Coordinator, on person-centered thinking and planning, including strategies to encourage the Member to exercise their own decision-making about their life choices, who provides their services, how they are provided, and where they are provided. The approach to planning will ensure:

- Members will be directly involved with the plan development, including choosing the people who participate.
- The meetings will be held at a time convenient for the Member.
- The plan will be written in plain language in a manner that is accessible to people with cognitive disabilities or those who may not use English as their first language.
- The plan will reflect the Member's strengths and preferences.
- Members will be offered a choice regarding services.
- Members understand their rights to choose their living arrangements and roommates, have ready access to food, and have the right to privacy.
- Risks will be identified, as well as methods to minimize them.
- Development of a backup plan in case the Member's support staff does not show up for work.
- If any restrictions to the individual's rights, preferences, choices, etc., are in the plan, there will be sufficient documentation to support the necessity for the restriction, including a discussion of other interventions used, time limits on the intervention, and appropriate documentation, including the individual's informed consent.
- The plan will be signed and agreed upon by all individuals and Providers responsible for implementing the plan, including signatures of all Providers (and individuals if applicable) who are identified in the plan as being responsible for supporting the Member in meeting stated goals.
- Role of the Care Coordinator and TCM/CCC in monitoring settings and the Member's experience.
- Opportunity to review or revise the plan upon request or with a change in circumstances.

Healthy Blue trains our Care Coordinators and delegated TCM/CCC to develop a Person-Centered Service Plan (PCSP) that is sustainable and considers mitigation strategies to divert the Member from inpatient admissions or institutionalizations. When developing the Member's PCSP, our Care Coordinators work with the Member to identify an appropriate setting that enables them to live as independently as possible in the community setting of their choice. When evaluating a new residence, Care Coordinators confirm that the residence does not have characteristics of an institutional setting and respects the Member's choice and autonomy. Our *Automated Referral Tool* allows us to send automated referrals to Providers and track their availability and capacity to provide the service. Once the Provider accepts a referral, the Care Coordinator will work with the Provider to review the PCSP and individual Member goals associated with the service to ensure they are equipped to provide the service.

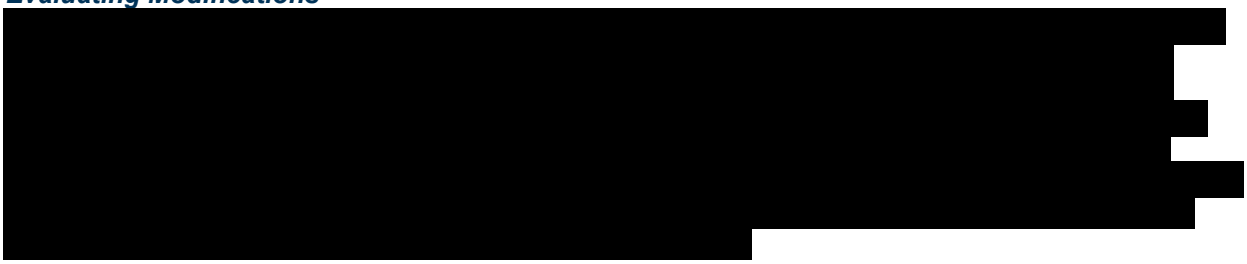
Implementing and Supporting Necessary Modifications. Healthy Blue's PCSP includes a section focused on evaluating modifications to highlight any modifications and ensure they receive a thorough initial and ongoing assessment. During the planning process, if the need for a modification arises, we will complete the following steps and document in the Member's PCSP:

- Identification of the specific and individualized assessed need for the modification.
- Positive interventions and supports used prior to any modifications to the PCSP.
- Less intrusive methods of meeting the Member's need(s) that have been tried but did not work.
- Descriptions of the condition(s) that are directly proportionate to the specific assessed need(s).
- Schedule of contacts and time limits for periodic reviews of the plan to determine if the modification(s) are still necessary or can be terminated.
- The Member's informed consent for any changes.
- Assurance that the interventions and supports will cause no harm to the Member.

For example, if a Member is diagnosed with Prader-Willi syndrome, which causes a constant craving for food, resulting in rapid weight gain, through the person-centered planning process, there may be a recommendation from the physician to limit access to food during certain times of the day. Before approving this recommended modification, the Care Coordinator or CCC/TCM, depending on the waiver, will first determine what other less restrictive options should be considered. If it is determined that limiting food access is the most appropriate course of action, the Care Coordinator or CCC/TCM will review with the member and/or their designee to ensure they understand and are in agreement and document the specifics of the modification in the PCSP, including the time frame for a follow-up review to evaluate the modification and determine if it can be removed. In addition, the support team will continue to explore other potential strategies that could be tried, such as focusing on food security and positive behavior support strategies implemented on a consistent schedule with the goal of decreasing and removing the restriction safely over time.

The modification assessment and evaluation process is critical to ensuring that inappropriate restrictions are never placed on individuals receiving HCBS services. Healthy Blue is committed to fully complying with these elements of the HCBS Final Settings Rule.

Evaluating Modifications



Monitoring to Ensure Ongoing Compliance

Healthy Blue will continuously evaluate HCBS Settings in our Provider network to ensure Members receive person-centered care that enables them to achieve their goals of independence and complies with the HCBS Final Settings Rule. Our comprehensive monitoring process includes Care Coordinator contacts, PCSP audits, and Provider site visits, as described here.

Care Coordinator Contacts

Through regular Member contacts, the Care Coordinator will confirm the Member is living in an integrated setting that meets their needs and complies with the HCBS Final Settings Rule. During these visits, the Care Coordinator will confirm that the Member understands their rights to come and go at their preferred schedule, have visitors, decorate their rooms, lock their doors, and other key elements of the HCBS Final Settings Rule. The Care Coordinator also confirms the Member knows how to report any concerns regarding abuse, neglect, or exploitation.

If a Care Coordinator identifies that a Member may be living in a restrictive setting or if they have potential concerns, the Care Coordinator will immediately evaluate the Member's safety and confirm they

understand their rights to choice, dignity, and privacy. They will notify Provider Relations to conduct timely outreach to address the Provider compliance violation and establish a mitigation plan. At the Member level, Care Coordinators will engage the Member and their Interdisciplinary Care Team to determine appropriate steps to remediate the issue or locate an alternative setting that may be more fully integrated. We recognize that Members always have a choice among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.

PCSP Audits

Healthy Blue's Audit team will complete a quarterly audit of a random sample of PCSPs to monitor the integrity of the person-centered planning process and compliance with the HCBS Settings Rule and state and federal rules. Quarterly audits will assess adherence to standards related to:

- Assurance that the care plans meet Members' assessed needs and individual goals.
- Care Coordinator application of person-centered practices, including encouraging Member participation in service planning and honoring the Member's choices.
- Compliance with the HCBS Final Settings Rule, including preventing rights restrictions and evaluating the efficacy of the modification process.
- Timeliness of assessment completion, service planning, and service initiation.

The Audit team will report findings to our Care Coordination and Provider teams for follow-up as needed. Our Care Coordination team will resolve Member-specific concerns and work with our Provider team to ensure that the Members we serve have access to community-based settings that promote independence and respect their privacy and dignity.

Healthy Blue recognizes and respects the transformational impact the HCBS Final Rule has had on HCBS Services. We are committed to partnering with KDADs, Providers, and MCOs to improve the experience for individuals receiving HCBS services.

Q.3. Can you describe specific efforts you plan to execute to address workforce shortages in Kansas, including specific workforce development strategies. Be specific as to the priority practitioners your focus will be on, and how you will address specific gaps in rural and frontier areas.

A.3.

Addressing Workforce Shortages in Kansas

Healthy Blue is devoted to ensuring Kansans have access to quality care. We recognize the critical role Managed Care Organizations (MCOs) play in addressing the workforce shortage, and our organization's 33 years of experience navigating the evolution of the health care industry workforce equips us to address various workforce development (WFD) related requirements. We have a responsibility to support communities dealing with critical workforce shortages across Kansas. Recognizing that WFD is a system-wide issue, we encourage collaboration. We aim to join forces with the State, other MCOs, Providers, Provider associations, schools, community-based organizations (CBOs), and national experts. These partnerships are significant in planning and implementing WFD strategies and activities to increase workforce capacity effectively.

Healthy Blue has developed a comprehensive approach to address Home- and Community-Based Services (HCBS), Behavioral Health (BH), and physical health, WFD challenges across the State to ensure all Members have timely and equitable access to the services they need. As part of Healthy Blue's WFD plan, key strategies and aligned tangible actions — outlined below — will be executed with a strong focus on recruitment, retention, and training.

Identifying WFD Capacity Needs

Our strategy is built on the effective use of data to identify current and future workforce capacity and determine priority practitioners for Long-Term Services and Supports (LTSS), BH, and physical health — a tactic that aids in the successful development and implementation of Kansas-centric WFD strategies. The main practitioner types facing these shortages include PCPs, dentists, mental health professionals, OB/GYNs, and nurse practitioners; as well as direct care workers.

To centralize efforts, and identify and develop comprehensive WFD solutions, Healthy Blue will invest in a staffing model that supports WFD efforts across the State. The overall role of our ***WFD Manager*** is to improve workforce capacity and capabilities to meet Members' needs and bolster Providers' ability to recruit, hire, and retain staff. This role is pivotal in strengthening WFD programs to benefit Providers, their staff, and Members; thereby ensuring the delivery of high-quality care.

The WFD Manager will coordinate and oversee various workforce activities in collaboration with the Provider Relations teams. The team will work collaboratively with diverse stakeholders, including Providers and the State, to develop and implement effective WFD strategies. They will continuously monitor and assess the current workforce capacity, track Member needs, and identify staffing gaps. They will offer crucial support and resources to Providers that encompass training opportunities, recruitment assistance, and technological tools. [redacted]

Identifying LTSS Capacity Needs

The Healthy Blue WFD plan will establish a clear path for evaluating and identifying LTSS provider capacity needs and a plan for supporting providers in mitigating barriers to recruiting, retaining and training their workforce. We understand that develop a comprehensive strategy, we must begin by collecting baseline data.

We will collect and analyze data and information to regularly monitor and assess our current workforce capacity and capabilities at least monthly, including specific metrics related to forecasting direct care worker availability to assure adequate workforce and Access. [redacted]

Identifying Rural and Frontier Capacity Needs

Our Kansas data analysis indicated workforce shortages have the greatest impact in Northwest and Southwest Kansas. Part of our WFD approach will include tailoring our proposed WFD strategies by county, based on our comprehensive assessment of Provider capacity for Go-live. In reviewing the GeoAccess reports of the current KanCare networks, we also noticed many frontier counties lacked access to Allergy, Dermatology, and Gastroenterology specialists. Anticipating these challenges, we have preliminarily developed both short- and long-term solutions. In the short term, we will offer eConsults, where PCPs can access physician-to-physician consultations across more than 70 specialties, including Allergy, Dermatology, and Gastroenterology. Our long-term strategy will continue to mature as we gain more data-driven insights from participation in the KanCare program, but we anticipate following strategies that emphasize non-traditional recruitment, retention, and training.

With 36 of the State's 105 counties categorized as frontier, much of our WFD strategy is centered around improving access across all specialties; however, low capacity for certain priority Provider types present cascading challenges to the health of Members in Rural and frontier areas. For example, according to the March of Dimes, 51 Kansas Counties are maternity deserts. Seventy thousand Kansas women live in a Kansas county without a single OB Provider. Along the Colorado border, Wallace and Greeley counties have no hospitals offering maternal care, no mental health Providers, and no dentists. In addition, in December of 2023, HRSA estimated that more than half (169 million) of the US population lives in a

Mental Health Professional Shortage Area (Mental Health HPSA)[1]. The national shortage of BH Providers is even more pronounced in Rural and frontier areas. For example. there is only one psychiatrist in all of Southwest Kansas, with a 1:176,738 ratio[2].

We prioritize these Provider types in the development of our Kansas-specific ***Rural and Frontier Health Strategy.*** With more than two million Members who live in Rural or frontier areas nationwide, our organization's extensive experience has enabled us to gain the insight necessary to develop proven solutions aimed at addressing health inequities faced by this population. We are also committed to developing a **Rural Provider Advisory Council** to gain insight directly from Rural Providers on better ways to serve Rural communities. A key component of executing this strategy is our ***Rural Health Specialist*** who will work hand-in-hand with Providers, meeting them where they are to address access to care and Provider shortage challenges in unique and practical ways.

Specific Workforce Development Strategies to Address Priority Practitioners

Through network development, we will connect with Providers to understand their current workforce capacity and connect them with best practices in recruiting, retaining, and training to strengthen their workforce. In Tables 3-1 through 3-5, we describe the specific WFD strategies we will implement to address workforce shortages in Kansas in accordance with local need and best practices and aligned with our focus on recruitment, retention, and training. Each table represents the Provider practitioners specifically targeted with each WFD strategy, or if they apply to various practitioners which includes those providing primary care, maternal health, BH, LTSS, and/or Rural Health.

[redacted]

Strategy	Description
Early Opportunities for Health Care Careers	In November 2023, Blue Cross and Blue Shield of Kansas donated $600,000 to the Wichita State Tech Foundation and the Future Ready Health Care Center to introduce high school students to potential health care related careers.
Statewide Workforce Development Plan	Healthy Blue's workforce development manager and Provider Relations teams will develop an annual statewide WFD plan. The plan will build upon resources and investments in the workforce that are driven at the State level, as well as develop and implement interventions to improve workforce capacity. In alignment with the statement of services, this plan will establish short- and long-term goals designed to expand the capacity of the Provider workforce.
Recruitment Plan	Based on data gathered through mapping programs, complaints, Member Grievances, and captured in Care Central, Providers will be actively engaged to help develop recruitment strategies that are both Provider and membership trend specific.
Provider Consult	Our WFD Manager will offer consultation with Providers to evaluate recruitment processes and help refine processes. This may include improving job postings, leveraging recruitment tools and incentives, and increasing interest by using titles such as Community Integration Specialist rather than DSP.
Provider Custom Toolkit	[redacted]

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

[2] Addressing Behavioral Health Workforce Needs in Kansas - Kansas Health Institute (khi.org)

	[redacted]
VBP Opportunities	We will use innovative value-based purchasing (VBP) strategies to incentivize Providers to develop new service delivery options and job structures to increase capacity through staff retention and development. Across all VBPs and Provider types, we will include key measures to incentivize Provider agencies and organizations to make ongoing efforts to recruit, hire, retain and ensure a high-quality workforce, resulting in increased quality of care delivery.
CareBridge's Member Support Program	[redacted]
Elsevier	[redacted]
CHW Supports	Healthy Blue funding was used to certify and train 10 Promotoras (CHWs) to further increase outreach and provide more one-on-one assistance to individuals. Promotoras de Salud is a term used within Salud + Bienestar to describe trusted individuals who empower their peers through education and connections to health and social resources in Spanish-speaking communities. They use their insights and knowledge of cultural norms to provide relevant health information and education to help Hispanics work through the barriers they face when addressing complex issues such as navigating the health care system, qualifying for certain health services, and comprehending the health service in general.
Maternal Health Grants	We will provide grants to local community organizations to address maternal and paternal gaps faced by Black women. We provided a $75,000 grant that funds maternal health services and resources in Douglas County, including doula services for 50 birthing individuals and the development of a maternity and birthing supply closet. An additional $50,000 was invested in Kansas Birth Equity Network to increase awareness and solutions specific to improving Black maternal, paternal, and infant health through training, research, health care, and advocacy.

[redacted]

[redacted]	[redacted]
The Skills System	The e-learning Skills Basics course teaches users the nine core skills and System Tools in the Skills System. Providers and their staff receive free specific online training and expert consultation, and learn ways to help transform their organization to better support individuals with IDD and dual diagnoses. There are video lessons, practice exercises, and visual aids to download. It takes approximately 2.5 hours to complete. Programs like this increase awareness and appreciation for the importance of integrated care models, allowing Providers to become more familiar with coordinating and collaborative care — and become better able to identify areas where such integrated collaboration would be more effective.
[redacted]	[redacted]

[redacted]

Strategy	Description
Scholarships	We will engage local colleges to partner with and provide scholarships for programs that would create a pipeline of the direct care workforce. [redacted] We will also offer scholarships to dental students who are from underserved areas and populations or commit to practicing for five years in underserved or tribal areas throughout Kansas.
Capacity Building Grants	[redacted]
Mobile Health Clinics	[redacted] Our Community Relations Representatives will drive two mobile clinics, primarily in Rural and frontier areas, at least four days a week and more as needed. We will partner with CBOs, churches, FQHCs/RHCs/FBCs, and medical centers to address SDOH needs and connect the community to resources.
Telehealth Solutions and eConsults	[redacted]

	[redacted]
Enhanced Clinical Support	Project ECHO® allows for Rural and frontier Providers (and any Provider, in reality) to access the support and consultation of specialists across the State on a variety of presenting issues. This increases the reach of specialists to extend their presence and expertise to Rural and frontier areas, and it improves the breadth of services that Rural and frontier Providers can provide to Members. In addition to allowing Rural and frontier Providers consultation with specialists, it also provides those same Rural and frontier Providers with Continuing Education Credits by participating in the ECHO clinics. While this is not an exclusively Healthy Blue service, we encourage all Providers to explore the benefit of Project ECHO participation — both for their own professional growth and for their Members as well.
Tribal Investments	Our plan's Tribal Liaison will be recruited from the Kansas AI/AN community, prioritizing community members who are also enrolled KanCare Members. The Tribal Liaison will be an additional resource in outreach to new plan Members who are also enrolled Members of federally recognized Tribes. We will use our relationship with Haskell Indian Nations University in Lawrence, Kansas, a national leader in education for AI/AN communities, to train additional health care workers — especially those interested in serving AI/AN individuals who live in Rural and frontier areas. Healthy Blue provided $25,000 in scholarship funds to Haskell University for students seeking associate degrees in Community Health and Social Work to cover things like technology fees, transportation, and childcare while the student takes classes, since their tuition is covered through a federal program. Additionally, Healthy Blue established a $15k Social Determinants of Health (SDOH) pantry support to further reduce barriers for AI/AN students. Haskell's student body reflects a higher population of students from Rural and Frontier areas as well as students with ties to Kansas' reservation lands, which makes their students more likely to return to and serve those communities with a high need for health care professionals. In 2023, Healthy Blue provided breakfast to celebrate and support the return of the Kansas Alliance for Tribal Community Health (KATCH) Tribal Health Summit. This inter-tribal event provides information, training, and resources that impact health and wellness that directly impact Kansas tribal communities.
Local Recruiting	Focused efforts in recruiting community members of Rural communities to serve in flexible support roles. Once we understand the gaps in a certain community, we will work with community partners to have focused job fairs that provide education and recruitment efforts targeting the needs of that community. Examples could be focused recruitment of Supported Employment Job Coaches, with inclusion of the ACRE training or focused recruitment of community members to provide Residential Supports for Adults or Children, in their own home (foster care home). Many human resources already exist in Rural communities and can be leveraged by health care organizations to improve services for Members.
Provider Partnerships	We will partner with community Providers, all available Providers in Rural and frontier areas, and Providers in contiguous states and incentivize network participation with APM. For Providers currently operating within Rural and frontier communities, there will be a focused effort to supporting them in expanding and diversifying the services they are offering. Through the use of data generated by Care Central and the national workforce dashboard, Providers will better understand where the expansion opportunities exist and can make effective business decisions to expand and/or

	diversify their service offerings. Through access to Elsevier, Providers can expand training of DSP to increase competencies leading to flexibility in the service types they support. This could include having a residential support Provider expanding the supports they provide to include in-home personal care services, and/or transportation. Another example is working with a Personal Care Services Provider to expand their support to include Supported Employment Job coaching through funding of Association of Community Rehabilitation Educators (ACRE) training. The roles of health care and social service Providers in Rural and frontier areas require flexibility, given the lack of resources for their work and an abundance of need in their communities. By exploring opportunities to adapt the roles of currently employed individuals will allow us to better meet the needs of Rural Members and address geographic barriers faced.
VBP Programs Designed for Rural and Frontier Providers	[redacted]

In conclusion, Healthy Blue is committed to resolving workforce shortages in Kansas, with a particular focus on Rural and frontier regions and priority practitioners. Our plan incorporates measures to not only foster health care opportunities and enhance recruitment, but also empower members and forge potent partnerships. Our underlying principle is concentrated on capacity building for prioritized practitioners to ensure all residents receive high-quality care. The diversified and comprehensive approach adopted by Healthy Blue is testament to our dedication to surmount workforce challenges effectively.

Q.4. Describe how you would identify HCBS service gaps to ensure authorized services are provided to members. How would you then address such gaps, particularly in areas of the state where self-direction may be the only option.

A.4.

Ensuring Authorized Services Are Provided to Members

Healthy Blue exemplifies a strong commitment to network adequacy and a broad choice of Providers, ensuring accessibility and compliance across their networks. We employ advanced technology to bolster the efforts of Care Coordinators, delegated Community Care Coordinator and Targeted Case Managers, and Provider Relations team, helping us to effectively monitor, identify, and fulfill any gaps in Home- and Community-Based Services (HCBS). By leveraging systematic data analysis, comprehensive Member outreach, and enhanced Provider support, we ensure the provision of authorized services to Members, regardless of their geographical location or chosen service delivery model such as self-direction and are quickly able to identify and address gaps. We also leverage the power of strong partnerships across our coordination and provider partners to quickly identify, address, and resolve gaps in real time and proactively examine network gaps by both service and location. We have experience leveraging data for both current and projected service needs to focus on areas for expansion before gaps occur to promote Provider expansion and recruitment.

Identifying HCBS Service Gaps

Healthy Blue employs a multi-dimensional approach to identifying and addressing HCBS service gaps by using both qualitative and quantitative data within the service structure. With our data analytics and technological capabilities, we incorporate Health Blue Care Coordinators' (Healthy Blue CC) understanding of the local landscape and Provider Relations team input, enable Member and family reporting, and include feedback from Providers and community partners to identify service gaps. Our *Automated Referral Tool* allows us to send automated referrals to Providers and track their availability and capacity to provide the service.

Care Coordination (Including Community Care Coordination/Targeted Case Management) Engagement

The Healthy Blue Care Coordination team is instrumental in the identification of service gaps. These teams will work closely with the Member to develop a Person-Centered Service Plan (PCSP) or Service Plan that clearly delineates each Member's individuals needs with a clear plan for the provision of HCBS services. Following the development of the PCSP or Service Plan, the Healthy Blue CC will contact the Member within five days of service initiation to confirm services have started and are being delivered in conjunction with the established goals and that Members are satisfied.

Provider Relations Input

During Provider onboarding, [redacted] he Healthy Blue CC will reiterate the expectation that they provide real-time notice of any issues with service provision or delivery, including assigning a backup Direct Support Professional to provide the service.

Enabling Members and Families to Report Service Gaps

Healthy Blue will provide Members with the tools and resources needed to notify Healthy Blue CC and Providers of service gaps. Members can contact the Care Coordination team or Member Services to reach the Provider directly or reach their assigned Healthy Blue CC through the Member website or Member Services line.

Incorporating Input from Provider and Community Partners

HCBS Providers and community partners providing non-paid supports are with Members, often daily. If there is a gap in services (with other Provider types) or any type of change in circumstances, the

Providers are typically the first to know. Leveraging them to support continuity across services and Provider types is a cornerstone of ensuring continuity and alignment with the PCSP or Service Plan.

Data Analytics and Technology

Using Electronic Visit Verification (EVV) data provides tremendous insight into identifying service gaps by tracking late or missed visits, when schedules are present, and reviewing data on caregiver observations. Our Healthy Blue team will use EVV data to track gaps in service and identify Providers who may have challenges with delivering services in accordance with the PCSP. In those instances, our Care Coordination and Long-Term Services and Supports (LTSS) Provider Relations teams will engage directly with Providers to develop a mitigation plan. Healthy Blue's local team will be supported by a national center of excellence with EVV subject matter experts who have experience in maximizing access to EVV data and establishing processes for action on this data across a variety of EVV models.

Addressing HCBS Service Gaps

While we implement many strategies and protocols to mitigate service gaps and provide continuous needed care, we acknowledge that unforeseen circumstances may cause a delay or gap in providing services. In these situations, we will take immediate action to initiate both short- and long-term strategies, ensuring the Member not only receives the immediate care that they need but in a way that accommodates their identified preferences and long-term goals. We will work collaboratively with the Member's CCC/TCM/CCBH to identify Providers to fill service gaps quickly. This includes using an emergency resource as part of their backup plan of care or receiving care from a trained and qualified self-directed worker. The Healthy Blue CC sends another automated referral to identify a backup Provider. The Healthy Blue CC will remain in contact with the Member until health and safety are fully addressed through whatever means are necessary. If a specific service is not immediately available, our Care Coordination team will work with our Specialty Provider Relations team to expedite onboarding of new Providers or to identify alternatives to meet the Member's needs, leveraging incentives or special rate agreements to support continuity of care.

Initiating the Backup Plan

As a crucial component of Members' PCSPs or Service Plans, we emphasize the significance of a robust emergency backup strategy to identify and proactively plan for how to address potential service gaps, particularly those that might arise from unforeseen challenges with direct care workers. Recognizing the vital role of relationships and community support systems, we identify natural supports, community allies, and other relationships that can be fortified and leveraged as backup resources during service disruptions. Prior to integrating them into the backup plan, we will obtain Members' explicit approval and commitment. By taking these proactive measures, Members will feel prepared when gaps in care occur, and they will know about the resources available to make sure they receive care when needed.

Supporting Self-Direction

Our goal is to always meet network adequacy and promote Member choice in determining their preferred service delivery model. In the event that there is an area where self-direction is the only service option, we will support Members and families to maintain continuity of care if there is an HCBS service gap. A key component to offering self-direction as a delivery model is creating a local pipeline for individuals in the community to know about and express interest in working in the self-direction program. We work closely with Fiscal Management Services (FMS) entities and CCC/TCM agencies to identify innovative approaches to identify workers and track these workers. As an example, we use the Kansas Rewarding Work Personal Care Directory or leverage other self-direction workforce databases and social media outlets. If a Member does not have a worker in mind, we will help them explore options within their local

communities. Partnerships with local organizations, family support groups, and peer organizations may be utilized to make connections and identify workers.

We will support Members and families by ensuring that they are positioned for success in the self-direction model and understand their roles and responsibilities as an employer. We will partner with their CCC/TCM as applicable, and FMS entity, who assists them with recruiting and identifying workers and performing background checks, and other administrative functions they perform as the employer. We connect Members with resources for recruiting and identifying workers and provide guidance on good hiring practices and scheduling to meet their support needs. During the worker onboarding process, Members are encouraged to set clear expectations for continuity and accountability when outlining job responsibilities as a key performance indicator. We will support Members in the development of their backup plan, which may outline additional workers or unpaid natural supports to fill gaps when scheduled workers are unable to work. Through monitoring of service utilization data combined with Member contacts, we determine if the Member is receiving adequate services to meet their needs and work to mitigate any risks and resolve barriers to meeting Member goals.

Healthy Blue is committed to our multi-dimensional approach to identifying HCBS service gaps and engaging innovative solutions to ensure each Member gets the authorized services, in accordance with their PCSP or Service Plan.

Q.5. With the vast number of benefits described that the plan provides, what is your approach to tailoring discussions with members to what is most appropriate to their needs?

A.5.

Approach to Tailoring Discussions with Members to Address Their Needs

Healthy Blue uses a tailored and person-centered approach to connect Members to the appropriate benefits based on their unique health needs and preferences. Our personalized approach is centered on three core principles:

- **Engage:** We meet Members where they are, using their preferred modality, to build trust and to identify the appropriate benefits that support their personal needs, preferences, and goals.
- **Educate:** We connect with Members early and often to help them understand the array of benefits available to them and how they can easily access these services and supports.
- **Empower:** We are focused on supporting Member voice and choice and empowering Members to play an active role in their health and well-being.

Tailored Engagement to Meet Unique Member Needs

Our engagement approach uses multiple modalities, including face-to-face visits, telephonic outreach, digital tools, and mail. We will engage Members as soon as they join our health plan through our new Member welcome calls, new Member mailings, new Member orientations, and Sydney Health (Sydney) mobile app messages. Each Member will be encouraged to complete their Member Health Screen, which aids us in identifying existing and emerging health needs.

Members with a higher level of risk or need will also complete a Health Risk Assessment (HRA) or a needs assessment, respectively. During the HRA and needs assessments, Care Coordinators will use motivational interviewing techniques to better understand the Member's medical history and any social needs, such as food or housing insecurity, transportation challenges, and more. Our Care Coordinators will be well-equipped to facilitate conversations with Members and provide local resources to capture their desired outcomes within a framework of how that person wants to be supported to achieve their goals.

We will engage Members to identify what is important to them, including any services and supports that have worked in the past. We will also make efforts to determine how they want to be supported in terms of their environment and routines that will set them up for success. This information serves as the basis for our person-centered planning process and guides the development of a Plan of Service or a Person-Centered Service Plan (PCSP) based on the Member's needs.

Our collaborative approach ensures that we connect Members to the right benefits at the right time to support their needs, preferences, and goals and drive improved health outcomes.

Educating Members about the Appropriate Benefits Available to Them

We use our multimodal engagement approach to educate Members early and often about their available benefits and how to access them so that they may fully utilize these services and supports.

All Members receive initial education as part of our new Member welcome approach, which includes a new Member welcome call orientation. During this time, we inform Members about our Value-Added Benefits (VABs) and where they can find more information about them, including on our Member website, within the Member handbook, and through the Sydney Health app.

Our engagement approach uses multiple modalities, including face-to-face visits, telephonic outreach, digital tools, and mail. Our Community Engagement team strategically partners with highly visible community partners that are considered pillars in their communities to ensure awareness with members and key stakeholders.

Telephonic Outreach. Comprised of phone calls and text messages, we educate members about our benefits and how to access them. Our campaigns use plain language and include easy-to-follow instructions to make the most enjoyable and informative experience possible.

Digital Outreach. Sydney is our secure Member portal and app, through which Members can see benefits appropriate for them, clearly outlined and explained. They will also be able to secure chat with a Member services representative if they have any trouble or need more information.

Mail Outreach. We have collaterals such as VAB fliers and instructional guides mailed to Members' homes in their preferred language whenever requested.

In-Person Outreach. Members with more complex health needs will meet with our Care Coordinators face to face so that we can better understand their personal goals, needs, and preferences. These face-to-face visits are often conducted in the Member's home, and they allow our staff to gain insights into the Member's social and health needs. We use this assessment to help us determine the Member's eligibility for benefits, including VABs.

REAL STORIES
Lupita's Journey:
Tailored Support for a Brighter Future

Our affiliate health plan, Wellpoint of Texas, Care Coordination team received a referral for Lupita, a 21-year-old Spanish-speaking, single, pregnant woman with identified risks related to depression and homelessness. Recognizing the complexity of her needs, which spanned prenatal and postnatal care, SDOH issues, and other community service, Lupita's Care Coordinator tailored support strategies to address her unique situation. The coordination involved:

- Scheduled support and OB RN coaching focused on pre-eclampsia
- Education on VABs and referrals to newborn care resources in the community
- Detailed discussions on DME benefits specific to breastfeeding needs and connections to WIC lactation consultants
- Ongoing screenings for postpartum depression alongside education on self-care and sleep hygiene

This individualized care approach significantly eased Lupita's anxiety, which had been magnified by her emergency C-section, her baby's constant need for physical closeness, and challenges related to breast feeding and supplementing.

With her anxiety reduced and sleep quality improved, Lupita has taken proactive steps by enrolling in English classes at a local church and joining a support group for mothers, organized by the local Catholic Church. She is motivated to learn English and earn a CNA certification. Lupita aspires to pursue a career in nursing.

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Other Modalities. For Members who are not engaged with a Care Coordinator on an ongoing basis, our engagement strategies are diverse and adaptive, encompassing telephonic and digital methods to ensure accessibility and convenience for Members, supportive of their preferred method of engagement and their preferred language. Our Member-facing staff, such as our Member Services Representatives, Community Health Workers, and Care Coordinators, are all thoroughly educated about our VABs so there's no wrong door for a Member. Staff will also employ motivational interviewing techniques and active listening to ensure that they fully comprehend the needs and preferences of each Member. This empathetic approach is critical in building trust and facilitating meaningful conversations that connect Members to the appropriate care and services they need to drive improved whole-health outcomes.

This multi-channel approach facilitates effective communication and engagement, enabling us to better uncover and address the health and wellness needs of Members.

Tailored Benefit Education Based on Each Member's Unique Health Needs.

Our Care Coordinators will use [redacted]

[redacted]

When any Member of the Care Team identifies a Member who would benefit from housing or employment supports, we refer them to our dedicated Housing or Employment Stability teams that work with each Member one on one to assess their needs, connect them to the appropriate resources and programs, and provide follow-up to ensure their needs are being met.

Educating Providers and CBOs to Connect Members to Their Appropriate Benefits

We work with community partners and Providers to identify and develop benefits that best fit the communities we serve. In addition to fostering transparent relationships, we host regular roundtable discussions with key stakeholders to ensure they are aware of our benefits and can strategize on new opportunities to support healthy lifestyles. Members are invited to engage with us in their communities, attend new Member welcome orientations, and participate in our Member Advisory Council. Emphasizing accessibility and transparency to our Members allows us to receive real-time feedback on current benefits and identify opportunities to further support eliminating barriers to healthy lifestyles.

We alert Providers to Members who may benefit from Healthy Blue benefits. For example, [redacted]

Empowering Members to Engage in Their Own Health Journey

Healthy Blue is there to support Members in living a life of their own design and achieving their personal health care goals. Our VABs engage Members in their own health and wellness journey and promote Member voice and choice by:

- **Offering incentives through our Healthy Rewards program** to encourage Members to complete healthy behaviors, such as wellness visits and annual dental checkups and closing gaps in care
- **Providing evidenced-based self-management tools** to help support Members with behavioral health (BH) and substance use needs, such as our Digital Mental Health Toolkit and Online SUD Recovery Support Program
- **Mitigating SDOH challenges that may prevent a Member from accessing care,** through benefits such as Transportation Essentials to help Members get where they need to go using their preferred method of transportation, and Fresh Food Connect, which allows Members to choose the food support that best suits their needs

We also ensure our VABs are not duplicative of Members' covered services or waiver services (when applicable). Our VABs are designed to enhance and "wrap around" our proposed clinical and SDOH programs and initiatives by connecting Members to additional services and products that will improve their unique health and social needs.

Digital Tools to Support Members.

We offer multiple avenues for Members to access their VABs to mitigate Member abrasion. In addition to engagement in Care Coordination and outreach to Member Services, Members can access our VABs through our state-of-the-art digital tools such as:

Benefit Rewards Hub (HUB). The HUB simplifies the Member experience by providing an easy-to-use interface, enabling Members to view and immediately select available benefits as well as see their redemption status in real time.

Sydney Health. We believe in empowering Members to take charge of their health with powerful interactive tools in the palm of their hand. Sydney, our award-winning, secure web and mobile digital health hub, provides Members with an option to receive custom-curated content to support their journeys,

and access programs that align with their goals. Members can use Sydney to quickly connect to the benefits they need, whether it is talking to a doctor or finding a food pantry close to home. Sydney seamlessly interfaces with our Community Resource Link, through which Members can search for community resources such as housing, food, job training, and education that are convenient to their location and meet their preferences. Sydney will help them identify and access VABs aligned with their needs. For example, in our Kentucky affiliate, our Sydney app is the top referral generator for the state's smoking cessation program. Sydney can also send targeted notifications for events in the area, such as a health fair, mobile clinic, or other community event, as well as information on how to use our Transportation VAB to get there.

Approach to Adapting to Members' Needs Over Time

Our proposed KanCare VABs and SDOH benefits are carefully curated to address the specific health and social needs of KanCare Members today, using data information from our Kansas health needs assessment and stakeholder feedback. For example, to address the high prevalence of asthma in Kansas, we created our Asthma & COPD Toolkit. We also designed our benefits to mitigate SDOH challenges throughout the State that were frequently brought up during Listening Sessions, such as food insecurity and transportation needs. Finally, we utilized best practices and lessons learned from our affiliates in other markets to design benefits that will be highly utilized, provide value to Members, and positively impact their whole-health needs.

We are committed to offering all VABs throughout the duration of the Contract. However, if awarded a Contract, we will review our proposed VABs with the State to identify any benefits that the State believes do not add value and remove them from our portfolio.

To ensure our VABs provide value to Members, we conduct a quarterly evaluation that utilizes:

- **Data and information,** such as utilization data for each VAB, claims data, and gaps in care reporting, impact on HEDIS® measures and costs of care, and more. We also use the HUB's reporting dashboard, which allows us to review a specific Member's benefit utilization, review each VAB's performance over time, and review our holistic Healthy Blue VAB portfolio for a more comprehensive view.
- **Member feedback on VABs** using Member satisfaction surveys, Member Advisory Committee and Caregiver Advisory Committee meetings, Member calls with Care Coordinators and Member Services, community events, and more. We will also host monthly Listening Sessions with Members to get feedback on a variety of topics, including VABs and areas of improvement. We will use data and feedback from our SDOH Social Resource team to understand the impact of our VABs on Member's social needs.

If we identify a VAB with low or no utilization during our quarterly review, we will take immediate action to resolve the issue, using an action plan that includes:

- Identifying barriers that may be preventing Members from accessing the VAB using Member Advisory Committee Meetings. Barriers may include, but are not limited to, gaps in Member education about the benefit and technology challenges that may prevent Members from accessing their VABs online.
- Mitigating these barriers through targeted outreach and education, one-on-one support to help Members with technology challenges access their benefits, etc.

If we complete the assessment and determine the VAB is not providing value to Members, causing low utilization, we will engage in discussions with the State about modifying or removing the VAB from our portfolio. We will also continuously refine our best practices and lessons learned from our VAB evaluations in other markets to inform our approach as we add new VABs annually during the State-defined time period.

Healthy Blue will meet Members where they are, empowering them to take an active role in their health. Our personalized approach aims to drive greater health outcomes that ultimately enhance the well-being of Members.

Q.6. Describe how community care coordination would be integrated with your overall model of care. Specifically address roles, responsibilities, and care coordination oversight

A.6.

Integrating Community Care Coordination as Part of Our Care Coordination Model

Healthy Blue's Care Coordination model for Long-Term Services and Supports (LTSS) Members is comprehensive, integrated, and geared towards providing whole-person care. Our model includes specialized Care Coordinators trained to support individuals receiving LTSS. This team serves as the nexus of a Member's health care, coordinating with the Member, their caregiver, and Providers, among others, to ensure optimal care delivery. The model adopts a person-centered approach, aligning individualized support based on the Member's goals. Each LTSS Member receives a Person-Centered Service Plan (PCSP) that includes an Interdisciplinary Care Team (ICT) in accordance with federal and State regulations.

We will integrate Community Care Coordination (CCC) into the model by ensuring a clear understanding of roles and responsibilities, as outlined in Appendix L, and establishing robust bidirectional communication and comprehensive data sharing, ensuring a seamless experience for the Member. The integration process places emphasis on a single point of contact for the Member, facilitating personalized care. We know integrating CCC in our model of care is instrumental to reducing fragmentation, eliminating duplication, and improving the quality of the person-centered planning process. We will promote an environment of shared decision-making that honors the institutional knowledge and expertise of the CCC while aligning with the foundational components of Healthy Blue’s approach to Care Coordination.

Our organization has extensive experience partnering with delegated CCC Providers to effectively support Members, including older adults and individuals with disabilities who will be supported by CCC, and individuals with Intellectual and Developmental Disabilities supported by Targeted Case Managers, as outlined in Appendix L.

National Experience in Delegated Community Care Coordination

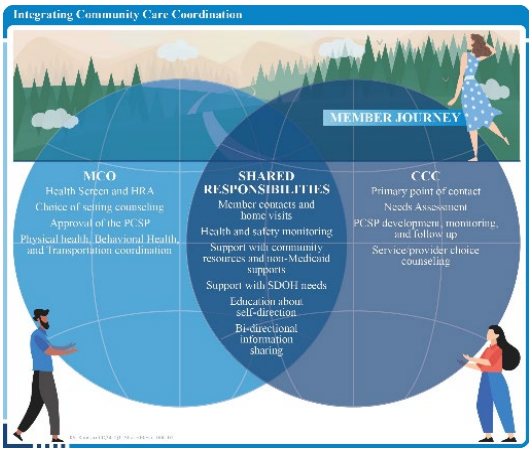
Through our affiliate health plans, Healthy Blue brings to Kansas extensive expertise in integrating delegated CCC into the Managed Care Organization (MCO) overall model of care.

- In California, our affiliate health plan monitors and oversees delegated Care Coordination partners. The affiliate health plan reviews and monitors their performance via our [redacted]
- Similar arrangements exist in other states, such as Texas, Arkansas, and New Jersey, where health plan affiliates are responsible for integrating and overseeing delegated Care Coordination.
- The Indiana PathWays for Aging program will launch in July 2024 with a delegated coordination model for adults over the age of 60. In this model, our affiliate health plan will delegate 50% of all service coordination to Area Agencies on Aging and Disability, and the MCO will maintain responsibility for all physical health and Behavioral Health (BH) services in addition to monitoring the efficacy of the person-centered planning process. [redacted]

Healthy Blue’s overall model of care provides Members complete control over their health care. Through clearly defined roles and responsibilities and strong oversight, Healthy Blue Care Coordinators (Healthy Blue CCs) and Community Care Coordinators will work together to ensure a seamless experience for all Members. We will provide training, support, and straightforward policies and procedures to ensure this delegated approach will not affect Member experience.

Defining Roles and Responsibilities for Care Coordination

Healthy Blue will adhere to KanCare Scope of Services guidance regarding the primary responsibilities of Healthy Blue CCs and Community Care Coordinators as described in Appendix L. The Community Care Coordinator will serve as the primary point of contact for the Member. They will be responsible for assessing and coordinating Waiver services, while our Healthy Blue CC will contribute to the delivery of Waiver services and maintain primary responsibility for coordinating physical health, BH, and transportation services.



The Community Care Coordinator will be responsible for completing the needs assessment, development of the PCSP or Plan of Service, and Provider/service counseling with the Member. Our Healthy Blue CC will complete the Health Screen and Health Risk Assessment (HRA); coordinate physical health, BH, and transportation services; and support Members in making informed choices about their preferred service settings (institution or HCBS) and self-direction options. Our Healthy Blue CC will also review and approve the PCSP as developed by the Community Care Coordinator.

Our Healthy Blue CC and the Community Care Coordinator will both participate in holistic service planning to ensure the Member benefits from each Care Coordinator's unique resources and skill sets. Coordinators will work together to support each Member in achieving their desired outcomes. Both Coordinators will be responsible for ongoing health and safety monitoring and, based on the goals shared by the Member, linking them to community resources by making referrals for education, employment, and housing services where necessary. Through timely and ongoing communication, our Healthy Blue CC and the Community Care Coordinator will effectively collaborate to reduce duplication and ensure Members have the support to lead their care planning toward improving their health and well-being.

To ensure consistency, our dedicated LTSS Trainer and local training team will collaborate with our LTSS Center of Excellence to train Healthy Blue and CCC teams on their roles, responsibilities, and shared processes for integrated Care Coordination. Our local training team will conduct training for Healthy Blue CCs and oversee the training of Community Care Coordinators, as necessary, to ensure alignment between expectations and quality of training.

Communication and Information Sharing

It is the responsibility of both the Community Care Coordinator and Healthy Blue CC to monitor service delivery for effectiveness and Member satisfaction, and to identify changes in the Member's condition or situation. While each Coordinator will provide a unique perspective, it is imperative that the Member's experience is not burdensome or duplicative. The Healthy Blue CC will contact the Community Care Coordinator upon identification of mutual Member assignment to share information and review the initial Member outreach plan. They will defer to the Community Care Coordinator as the primary point of contact and offer to support as needed. During PCSP development, we will capture the Member's contact preferences, including their communication preferences (phone, email, text, in-person) and days and times that are best. The Healthy Blue CC and Community Care Coordinator will establish a communication schedule for coordinating ongoing Member contacts, including monitoring the implementation of the plan and updating as needed.

As part of the monitoring process, the Healthy Blue CC and Community Care Coordinator will partner to stay in touch with the Member, family or caregivers, and all key Providers to monitor the Member's health, social support status, and progress toward meeting PCSP and Plan of Service goals. The Healthy Blue CC will remain available to consult, but always supporting the Community Care Coordinator as the primary Member contact. Whether triggered by the identification of a need through data monitoring or reassessment, the Healthy Blue CC and the Community Care Coordinator will reach out to engage the Member and family or caregiver to discuss the PCSP or Plan of Service. In all our review and reassessment activities, we will

promote an environment of shared decision-making that honors the Community Care Coordinator, the Provider's expert knowledge, and the Member's right to be fully informed and involved in all aspects of care. Together, the Healthy Blue CC, Community Care Coordinator, Member, family, caregiver, and participating ICT Members will determine updates to the PCSP or Plan of Service. The Community Care Coordinator will document the changes and alert the rest of the ICT about care plan updates. The Community Care Coordinator will make the PCSP or Plan of Service available to the Member, family, PMP, and other Member-authorized parties. Access to the PCSP or Plan of Service will be available according to the Member's preference, including options for electronic or hard copy, as well as translated versions as needed. The ICT will have real-time access to an electronic version of the PCSP or Plan of Service in Provider360 and hard copies are available upon request.

System Support for Integrating Community Care Coordination

The Healthy Blue CC and Community Care Coordinator will work closely together to provide seamless, comprehensive service planning. [redacted]

Care Coordination Oversight

To uphold and maintain our accountability for our model of care and to ensure that we hold Healthy Blue CCs and Community Care Coordinators to the same high standards for process and performance, we will implement a performance oversight process for our delegated CCC partners. We maintain communications protocols and reporting processes to monitor CCC activities in real time, which allows us to immediately address Member needs and continuously assess alignment of Care Coordination activities with Scope of Services requirements. We will leverage multiple mechanisms to support CCC performance and compliance, including:

- [redacted]

Our dedicated Delegation Oversight team will complete a quarterly audit of a random sample of 25% of PCSPs and needs assessments from Healthy Blue CCs and Community Care Coordinators. Based on the results of the review, Care Coordination Supervisors may provide individual or group training. If a Healthy Blue CC's or Community Care Coordinator's aggregate score is below 90%, the Supervisor or CCC Administrator will develop a corrective action plan to address specific deficiencies. If we identify a Community Care Coordinator that is underperforming, our CCC Administrator will initiate a corrective action process. Community Care Coordinators will receive information related to the corrective action through both written and verbal communications. We will support the development of a mitigation strategy and our Kansas-specific resources will help improve the Community Care Coordinator's processes.

In conclusion, Healthy Blue leverages clear processes, aligned training, and transparent oversight to integrate CCC into our overall model of care and ensure the person-centered planning process is seamless for the Member. Our approach emphasizes personalization and whole-person care, with Care Coordinators working in synergy to assess Member needs, develop care plans, coordinate services, and connect Members with needed resources, ensuring timely access to services. Oversight is maintained through continuous quality improvement processes, which include monitoring and evaluating performance outcomes to enhance Member care and overall community health. By folding CCC into the heart of our model of care, Healthy Blue strives to achieve KanCare's goal of improving health outcomes for Members in an integrated and well-coordinated manner.

Q.7. Please elaborate on how you would improve in addressing patients who frequent the emergency room, focusing on your discharge planning process and methods to redirect these patients to other sites of care.

A.7.

Successfully Addressing Members Who Frequent the Emergency Room

Supporting and educating Members who frequent the emergency room (ER) is of critical importance to Healthy Blue. Not only are Members better served by using the most appropriate level of care (LOC), but we strive to help our health care system work better, not harder. Smooth and timely discharge processes and ER diversion strategies support ER Providers' and staff's ability to ensure access and quality care to other patients in need of ER services. Healthy Blue will employ a range of ER diversion strategies and interventions for high ER utilizers. We know that adequate discharge planning and appropriate redirection to other sites of care are critical components to reducing frequent ER usage, as many Members who overutilize the ER may face situations that delay their discharge or result in them returning to the ER. To improve appropriate usage of the ER, our overall strategy begins with a proactive approach.

Proactive ER Diversion Strategies

Healthy Blue understands that frequent causes for ER overutilization often include deficiencies in access, health literacy, or management of chronic care conditions. Members with Intellectual and Developmental Disability (IDD) and those receiving Long-Term Services and Supports (LTSS) can be at higher risk of ER utilization and longer ER stays, particularly when they have co-occurring Behavioral Health (BH) or substance use disorder (SUD) diagnoses or Social Determinants of Health (SDOH) needs such as housing or food insecurity. These populations require time-sensitive engagement and intensive cross system coordination to assure appropriate transitions out of the ER. Our proactive ER diversion strategies focus on these core issues and seek to prevent future ER overutilization and potentially preventable events. We address disease and medication management, along with addressing barriers to medication adherence, so that Members' physical health and BH conditions do not escalate and are managed with the support of their care team.

Our whole health approach aligns with Member education and outreach, Care Coordination, and Provider network collaboration to make sure Members receive the right care, in the right place, at the right time from the Provider of their choice. As part of this approach, we will educate Members and any familial supports in their care team on Preventive Care, condition and medication management, and the benefits of receiving and accessing care in the appropriate time and setting to avoid unnecessary use of ER. We also will ensure Provider network adequacy so that Members can access their PCPs and Specialists, including after-hour care via options such as telehealth and after-hour clinics. Some of our ER diversion strategies are outlined in Table 7-1.

Table 7-1. Examples of Healthy Blue ER Diversion Strategies

ER Diversion Strategies	
Technology and Data Analytics	
Data Analytics	We leverage predictive modeling to inform our stratification process to identify various high or emerging-risk populations that include readmission risk scores and Low Intensity Emergency Room (LIER) utilization risk. We proactively identify Members' needs and emerging risks to facilitate early intervention and provide timely support.
Monitor Readmission Rates	Our BH team will hold monthly meetings to review metrics such as readmission rates. We will analyze data beyond the Member level including outliers and patterns in volume by facilities and Providers. We will then share this data with Certified Community Behavioral Health Centers (CCBHCs) and Community Mental Health Centers (CMHCs) and other Providers as needed, promoting an integrated and collaborative approach to closing care gaps that may be contributing to readmissions. A Clinical BH Care Coordinator will call

ER Diversion Strategies	
	the Member and can conduct an in-person visit to assess needs and close care gaps. We will reach out to Members based on clinical acuity until needs are stabilized and can be transitioned into our Complex Care Coordination program which provides up to six months support from a dedicated Care Coordinator.
Focused Care Coordination Programs	Similar to the LIER process, Healthy Blue will also use predictive modeling to proactively identify members for focused care coordination programs such as the: ▪ Suicide Prevention Outreach Team (SPOT) program to identify Members at risk for a suicidal event in the next 12 months. We know that many who leave the ER for suicide ideation/attempts struggle with attending follow-up appointments and may present again at an ER in short period of time. The SPOT program focuses on safety planning, connections to needed resources, increasing utilization of outpatient and community supports, and removing access to care barriers to mitigate factors and stress that could increase the likelihood of a suicidal event. ▪ Resilience through Intervention, Support and Education (RISE) program to address social barriers to care and promote engagement for those at risk of developing adverse health outcomes associated with substance use. RISE aims to reduce overall use of acute services such as ER use, detox, and higher levels of care for SUD.
ER Alternatives	
Telehealth and Alternative Support	[redacted] We also promote local Urgent Care Providers, PCPs with extended hours, Dispatch Health for in-home Urgent Care support, telehealth and digital services through LiveHealth Online, the Sydney digital health app with live chat and symptom checker, and our 24-Hour Nurse Helpline.
In-Home Medical Kits	We partner with select Providers to distribute in-home medical kits to Members to support improved accuracy in the diagnosis and treatment of common health conditions via telehealth. The kits contain FDA-approved handheld devices that allow Members to check their temperature and perform live exams on the ears, mouth and throat, lungs, heart rate, and skin with the virtual guidance of their Provider from the comfort of their home or anywhere with a Wi-Fi connection. Members can also save the exams for their own personal records and email them to their PCP for follow-up.
Member Strategies	
Outreach	In addition to regular Care Coordination engagement, we proactively call Members who have not had a visit with their PCP for six months, offering to support them with appointment scheduling, transportation, and accommodations as needed. We also call Members identified with readmission risk scores and LIER utilization risk. We leverage Community Health Workers (CHWs)—or Community Health Representatives (CHRs), as appropriate—as boots on the ground for in-person visits. CHWs will connect with Members who have high ER use and do not have a documented PCP visit in the last two years. The CHWs/CHRs will connect the Member back with their Care Coordinator if there has been a gap identified, offer to connect the

ER Diversion Strategies	
	Member with their PCP, and schedule an appointment over a three-way call. For Members with BH conditions, we will leverage data indicating a missed fill of antipsychotic medications and outreach those Members to assess for gaps and remove barriers to getting prescriptions filled.
Incentives	We will offer meaningful incentives aligned with improving health outcomes, promoting primary and Preventive Care, and healthy lifestyles. For example, [redacted] We will also offer incentives for LTSS and foster care populations, such as completing trauma assessments and care plan updates. We will offer Member incentives in the form of gift cards to promote Members' engagement in their health care goals.
Education	We will provide proactive education and resources on the benefits of preventive health, medication management, condition-specific information, and topics such as when to call the Nurse Helpline, Behavioral Health Services and Crisis Line, 988, and local BH Crisis Care sites. We will educate Members on the services their PCP offers and Urgent Care alternatives. We will deliver text messages, emails, and targeted mailings; make phone calls, and post information to social media, the Member website, and our website. We will offer resources such as our Health and Wellness webpage which provides quick, easy access to information, interactive tools, and tips to help Members manage their health care and our Health A to Z, which provides information and answers on many health topics, a symptom checker, and interactive tools. Our h is not reserved only for excessive ER users, we focus on educating *all* Members. If we are unable to reach them, we will deploy our CHWs/CHRs and Certified Peer Specialists and collaborate with Community Care Coordinators to promote the probability of successful contact and engagement.
Address SDOH	Lack of adequate necessities for social resources such as transportation, employment, and housing are often barriers to a Member's ability to receive appropriate Preventive Care. To mitigate these barriers and encourage Preventive Care over unnecessary ER use, Care Coordinators and CHWs can engage our Social Resource team to further support Members with appropriate services and supports. Our dedicated Social Resource team specializes in connecting Members to employment and housing stabilization resources. We will offer non-emergency medical transportation (NEMT) services to all Members and educate them on covered NEMT availability and how to access it, especially in Rural areas. We also offer the Community Resource Link tool which connects Members to community-based resources to meet individual needs. We will remind Members of our Value-Added Benefits (VABs) that include [redacted] Addressing Member's SDOH needs can also support their ability to manage their chronic conditions, adhere to medication regimens, and attend routine Provider visits.

ER Diversion Strategies	
Member-Primary Care Relationships	We will encourage strong Provider-Member relationships by helping Members select a PCP who reflects and embraces their cultural preferences and background. Our continuously updated Provider Directory indicates various social demographics, location, spoken languages, and specialty information for all Providers. For example, if a Member is looking for a Provider in their county that is affiliated with a Tribal nation, they can specifically search for this criterion to find a Provider that meets their needs.
Chronic Condition Care	We will engage Members with chronic conditions in this Care Coordination program. Healthy Blue will address Members' health needs along the continuum of care by increasing Member participation and engagement and specifying interventions by condition. We offer Chronic Condition Care for conditions such as asthma, diabetes, hypertension, SUD, and major depressive disorder. We will encourage Member participation and facilitate opportunities for Members to independently manage their chronic conditions through VABs such as [redacted].
Provider Strategies	
Incentives	We will incentivize Providers to offer expanded hours and support Members with SDOH needs through enhanced reimbursement when they submit a Z-code diagnosis and follow up after Member referrals to confirm services were received. We will also leverage innovative value-based purchasing (VBP) models to reduce ER visits.
Education	We will offer education and tools for PCPs designed to help them improve quality, cultural sensitivity, and continuity of care for their patients with BH conditions. Our training covers understanding how to manage BH conditions in the primary care setting and guidance for conditions that are best referred to BH professionals.

Redirecting Members to Other Sites of Care

An integral component of managing frequent ER visits is to efficiently redirect Members to alternative, suitable sites of care rather than relying heavily on Emergency Services. This not only optimizes the utilization of limited ER resources but also makes sure that Members are receiving the most appropriate LOC for their specific health conditions.

We start by proactively educating all Members of alternative sites for care upon enrollment and on the Member website, our website, via proactive initiatives, social media campaigns, and through their Care Coordinator. When Members use the ER when another more suitable option exists, we will remind them of alternative options for treatment and when it is appropriate to leverage those alternatives. If unable to reach the Member through telephonic or digital means or if requested, we will conduct a home visit. As noted, some of the alternative sites of care we continually educate Members to leverage include:

- CareBridge 24/7 Provider support
- Urgent Care and PCPs with extended hours
- Dispatch Health for in-home Urgent Care support
- Telehealth and digital services through LiveHealth Online
- Sydney digital health app with live chat and symptom checker
- Healthy Blue 24-hour Nurse Helpline

A well-developed system for referring patients to other health care settings, including primary care offices, specialty clinics, or Urgent Care centers, based on their needs can greatly enhance continuity of care. Healthy Blue's strategy necessitates building solid partnerships with health Providers across the spectrum along with a consistent follow-up system to monitor the Member's progress post-discharge. This approach contributes significantly toward reducing repeated ER visits.

Identifying ER Members for Comprehensive Discharge Planning

Our discharge planning process includes comprehensive methods aimed at guiding Members toward the most appropriate LOC and ensuring they are set up with the resources and tools they need to be successful in that setting and continue to improve their health. We first ***identify Members in the ER or inpatient setting***. Notification of Members in these settings may be received through Admission, Discharge, and Transfer (ADT) data from participating facilities, Utilization Management (UM) nurse referrals from a daily census, or outreach communication from the facility clinicians. Our secure Provider portal is another useful tool for facilities to notify a Member's Healthy Blue Care Coordinator (Healthy Blue CC) and other members of their integrated care team, aiding in an effective discharge process and helping them finalize orders and connect with existing outpatient Providers.

We ***engage with Members and facilities*** in discharge planning as a key aspect in the process. Our Healthy Blue Discharge Planners and Transition Care Coordinators will provide crucial support to Members and facilities. They will help ***ensure access to immediate post-discharge services*** and link to a Member's care team which can include the Community Care Coordinator, when applicable. Our Discharge Planners are trained clinicians who take on specific facility assignments to expedite a Member's successful discharge. They address and help with authorizations for aspects of discharge such as ***newly prescribed medication, Durable Medical Equipment (DME), private duty nursing, and SDOH needs***. For Members discharging from a BH admission, a Transition Care Coordinator will support the discharge planning process, follow up with the Member, and monitor post-discharge needs and processes such as discharge follow-up appointments and discharge prescriptions fills. The Transition Coordinator will assure that the Member's Healthy Blue CC or the Community Care Coordinator has the needed information related to the acute episode to effectively follow up with the Member.

After discharge, the Member's Care Coordinator will ***follow up*** regarding the lead causes of the ER visit and ensure that the Member understands their discharge plan and there are no barriers to following it. They will also ensure necessary follow-up appointments are scheduled and necessary supplies, accommodations, and medications are received at home. They will assess the Member's needs and connect them to social supports as necessary. The Care Coordinator will also work with the Member to update their Person-Centered Service Plan (PCSP) or Plan of Service, as needed, and update their PCP and care team.

Our CHWs will be notified by ER or inpatient admissions and make the necessary outreach to help Members ***tackle SDOH gaps in care***. The CHW will collaborate with the Community Care Coordinator so that efforts are not duplicative. A home visit includes assessing their SDOH, physical health, BH needs, and addressing any of the circumstances that led them to choose the ER over another form of care.

Our process does not end at discharge. We will continue to ***educate Members on appropriate care settings*** and alternative treatment options to prevent readmission. Working with Members, Care Coordinators reinforce correct LOC utilization behavior.

Finally, we also have an interdisciplinary Lock-In committee that reviews details of Members with multiple ER visits in a short period. The committee evaluates the reasons for the visits alongside medication usage and diagnosis. This can trigger the necessity for BH or physical health Care Coordination services if not already under Care Coordination. Our Care Coordinators will reach out to these Members to address their needs and discourage ER visits for non-emergent concerns. Our dedicated Lock-In program provides Members with education to identify and reduce service overutilization by evaluating the reason for the Member's filling habits and assessing the whole picture, not just the claim.

Healthy Blue's approach to facilitating an efficient discharge planning process and redirecting Members to other sites of care keeps the Members' best interests at the forefront while optimizing the use of emergency resources. We will use a proactive, person-centered, and comprehensive discharge process to manage the issue of frequent ER visits. Our approach to ER diversion, discharge planning, and redirecting Members makes services and supports available and accessible for Members to properly manage their health conditions. Our approach prioritizes proactive planning, effective communication, Member education, and efficient utilization of non-emergency Health Care Services. Finally, through our

quality committee structure, we will continue to discuss and prioritize appropriate ER usage through individual and comprehensive analyses and strategies.

Q.8. Describe your plan to have a robust network of providers in place by January 1, 2025, to support consumers receiving services under the state's Home and Community Based Services, with a particular emphasis on the direct care workforce, and specialized in-home nursing services.

A.8.

Developing a Robust Provider Network by January 1, 2025

Healthy Blue currently meets all network adequacy standards for Home- and Community-Based Services (HCBS) statewide and will continually monitor its network and the capacity of Providers to support HCBS Members, utilizing the approach outlined in this response to attract and educate additional Providers, further improving access to care beyond adequacy standards. ***We recognize that meeting network adequacy does not always mean capacity exists to meet Members' needs.*** We will use our proven network development strategy to ensure that our HCBS network is comprehensive, with Providers educated and supported to meet the complex, ever-evolving needs of Members. Our network development strategy is designed to exceed adequacy requirements and provide Members with an ample choice of high-quality Providers to help meet their needs wherever they reside. Further, we will make sure Providers are positioned to meet the specific support needs and self-identified, person-centered goals of Members in a high-quality and timely manner.

To develop a robust HCBS Provider network, we will use a multi-phased approach to deliver tailored training and support to Providers serving the KanCare population. Through these phases, we will work to ensure that our Kansas HCBS Providers are equipped with the information and tools needed to continue delivering quality Long-Term Services and Supports (LTSS) services that honor Member choices and beliefs, display sensitivity to cultural diversity, and demonstrate attitudes and interpersonal communication styles that respect Member cultural backgrounds.

To ensure Providers are contracted and ready to serve KanCare Members upon go-live, we have deployed our LTSS education and outreach approach, which includes the following phases: engagement, contracting, onboarding, and ongoing education and support. Within each phase, we will train Providers through a variety of modalities to best accommodate the learning needs and availability of the LTSS Provider network. Our LTSS Provider Relations team will direct the responsibilities of Provider network development across HCBS programs. The details of this four-pronged approach is described in detail below.

Engagement

We understand the importance of early engagement with trusted Providers, stakeholders, and associations to build rapport. We are actively connecting with communities across the state to educate HCBS Providers about who we are and discuss joining our network, as well as to learn from them what their concerns are and where they struggle with meeting Members' needs with their direct care workforce.

We recognize that meeting network adequacy does not always mean capacity exists to meet Members' needs. In addition to current efforts to recruit HCBS Providers to join our network, we will engage home health agencies and HCBS Providers through regional townhalls and will use the information to ensure we meet and exceed traditional network adequacy to provide a Provider network capable of providing timely services.

Contracting

Our goal is to maintain compliance with and exceed network adequacy requirements by January 1, 2025, through executed contracts. Our Network Development team will conduct outreach to all contracted HCBS Providers to confirm demographics, specialty/services, and counties served in accordance with State requirements.

Healthy Blue demonstrates through proactive monitoring and analysis a procedure for developing the LTSS Provider network that will include the entire LTSS network by service and county, and the count of Providers in each — relative to the service needs of the Members we anticipate supporting, comparing access standards to the needs of service recipients to identify areas for expansion and efficiency. We will continually monitor the State data list to identify newly enrolled waiver Providers, to engage for contracting and ongoing support.

As we work toward a January 1, 2025 Contract go-live date, each HCBS Provider will receive either a virtual or in-person Provider Support Visit. We will provide additional support during the Provider Support Visit to help prepare for implementation, verifying they meet all requirements and qualifications to become a KanCare Provider, as applicable. Activities completed during this visit include but are not limited to:

A contract will be extended to Providers who meet the necessary qualifications and express interest in joining the Healthy Blue network.

Onboarding

Our LTSS Provider Relations team will conduct Onboarding and Education and Training Provider Visits within 30 days of the Provider being contracted. This visit will focus on ensuring Providers are educated and feel confident in understanding all contractual, State, and federal requirements, as described in their contract and Provider manual before providing support to KanCare Members. During this visit, their Provider Relations representative will:

Nursing Facility Onboarding. Our dedicated nursing facility (NF) Provider Relations Representatives will conduct NF-specific onboarding and education and training visits within 30 days of the Provider being contracted. NF visits are an essential step to foster collaborative relationships between Healthy Blue and NFs. The NF Provider Relations Representative will contact the NF to coordinate time to meet with their leadership, clinical leadership, and the Care Coordination team to educate them on:

[redacted]

In alignment with individual Provider needs, the dedicated LTSS Provider Relations Representative will engage other subject matter experts such as the [redacted] to support Provider readiness for implementation.

Ongoing Education and Support

The final phase offers ongoing and dedicated support for our Providers throughout the term of our participation in the KanCare program.

Healthy Blue's LTSS Provider Relations team will conduct a variety of ongoing activities to support Providers and respond to their emerging needs, ensuring continued and enhanced Provider experiences and satisfaction. We focus on building long-standing relationships and developing, expanding, and enhancing our network.

Provider Relations roles and responsibilities include:

[redacted]

Key performance indicators of this team include but are not limited to: membership compared to Provider network, Provider satisfaction, decreasing Provider complaints and escalations, increased value-based purchasing (VBP) program adoptions and utilization, increased Provider training and communication, WFD/increased Provider capacity, and timely service initiation.

Annual Ongoing Provider Support Visits. Our LTSS Provider Relations team will conduct annual Provider Support Visits in alignment with HCBS Provider certification, when applicable. During the visit, their dedicated Provider Relations Representative will re-verify pertinent information from the Provider's initial support visit as well as evaluate their overall performance since the last meeting. Based on performance, this time is used to conduct retraining or discussions on topics such as:

[redacted]

This visit may also result in a CAP or performance improvement plan if areas of Provider deficiencies are identified.

Additionally, ***HCBS Final Settings Rule Compliance Visits*** may be included within initial or ongoing Provider Support Visits to ensure ongoing compliance. The LTSS Provider Relations team will ensure, while onsite, that the Provider remains compliant with the HCBS Final Settings Rule and verify that the setting

does not have the qualities of an institution, that it is grounded in individual choice and provides full access to the community, and that Member and staff experience align with the Provider's policy and practice.

Innovative Approaches to Improve Workforce Capacity

We will implement the direct care workforce strategies (as described in detail above in our response to Question 3) during the readiness phase to increase HCBS capacity by addressing direct care worker and nursing shortages. Leveraging our organization's 25 years' experience building out comprehensive HCBS and Behavioral Health (BH) networks, we will offer a variety of WFD supports such as technology, training, financial support, and consultative expertise. Our approach includes developing and executing WFD that includes cross-functional experienced staff, collaboration with key stakeholders, data collection and analyses, and strategic interventions such as recruitment, retention, workforce alternatives, and impact evaluations.

Advanced Monitoring. Recognizing the importance of having a strong and ample direct care workforce, our dedicated LTSS Provider Relations team will leverage service initiation data to assess the time from referral to acceptance and the time from acceptance to start of services. This analysis highlights which services and areas of the state are experiencing challenges.

***Leveraging Partnerships to Improve Capacity*.** As stated above, we currently meet network adequacy for HCBS and have secured contracts with large home health/hospice Providers, such as Phoenix Home Health and Hospice in Hutchinson, Overland Park, Topeka, and Wichita. That said, we are continually looking to improve capacity.

***Alternative Capacity Solutions*.** We acknowledge the challenge in meeting the in-home nursing needs for families with children and youth with Special Health Care Needs (SHCN). We understand that Kansas is retaining the arrangement to pay family caregivers to meet this need under the 1915 (c) Appendix K flexibilities, and we pledge to support the families that have opted to remain in the paid caregiver status by providing information, training, and support to facilitate their requests for Durable Medical Equipment (DME) and medical supplies. We acknowledge that families may have chosen this route out of necessity due to lack of Providers. We will utilize the Provider network development strategies described in this section to arrange for traditional support should a family need or desire to move from paid family caregiver status.

***Supply Support*.** We understand that Members and families have voiced that having adequate DME and consistent delivery of essential medical supplies can be an issue when family members are providing direct care. To address this, we will tap into our expansive national network for DME, streamlining the process and making sure that Members have prompt and convenient access to the equipment they require. Knowing the pivotal role of Providers in addressing these needs, we will deliver Provider training to equip them with the knowledge and skills to prescribe DME promptly and accurately to simplify the process for Members and their families. Our Care Coordinators will follow up on every order for DME to ensure timely delivery regardless of payor source. When a Member is dually eligible, we coordinate with the Medicare Care Management team to facilitate the DME process and avoid unnecessary delays. We will also work with home health agencies to expand delegated nursing services where possible to increase capacity for specialized in-home nursing services.

Healthy Blue is deeply committed to establishing a robust Provider network by January 1, 2025. With a focus on enhancing HCBS, we aim to not only meet but exceed the network adequacy requirements, offering Members comprehensive support tailored to their individual needs. Our strategy involves a proactive approach in engaging with existing Providers, facilitating early and ongoing education and support, preparing Providers for implementation, and continually monitoring network development. We also place a particular emphasis on cultivating the direct care workforce, recognizing its vital role in delivering specialized in-home nursing services. It is our mission to support Providers, develop meaningful collaboration, and foster an environment that places the needs of Members at the heart of care delivery. Healthy Blue stands ready to invest, intervene, and innovate to deliver this vision for all our Members within the KanCare program.

Q.9. Please outline the criteria you use to determine the placement of Community Health Workers. Please describe how you will collaborate with the Medicaid team on Community Health Worker strategies/deployment?

A.9.

Strategically Defining Community Health Worker and Community Health Representative Placement Criteria

Healthy Blue knows the value of using Community Health Workers (CHWs) and Community Health Representatives (CHRs) to engage Members and meet them where they are. Therefore, our criteria and placement of CHWs/CHRs revolves around the needs of our membership. To best deploy this type of highly effective Member engagement, we have defined strategic and specific criteria that will guide the most effective placement of CHWs and CHRs across the State.

Community Health Worker and Community Health Representative Strategies and Deployment

Healthy Blue will ensure that all CHW and CHR deployment is done strategically and purposefully to best serve Members.

Further, we will leverage CHWs/CHRs already employed with Kansas community-based organizations (CBOs) to help connect Members to services and resources and reduce disparities. We will encourage Providers to allow for CHWs/CHRs to be embedded in their practices and to engage in the health care processes.

In addition to collaborating with the State and aforementioned CBOs, we will work with other statewide groups such as the Kansas Community Health Worker Coalition to ensure success. We will also partner with CHWs who are embedded within Federally Qualified Health Centers (FQHCs), Community Mental Health Clinics (CMHCs), and Certified Community Behavioral Health Centers (CCBHCs) and partner with those individuals to help better serve Members.

Q.10. In regard to Utilization Management, what processes do you have in place to assure that providers will have a true peer (i.e. same specialty) when appealing a decision?

A.10.

Healthy Blue's Peer-to-Peer and Appeal Process

Healthy Blue encourages conversations with Providers to gain perspective on the Member's holistic needs. When a Provider requests a peer-to-peer discussion, our clinical team will expeditiously coordinate a conversation with one of our board-certified Medical Directors, which allows us to more fully understand the Member's needs and leverage our Care Coordination model and whole health strategy. Internally, we have multiple specialized clinical teams with dedicated Medical Directors to exclusively review cases such as NICU, DME, Psychological Testing, and Applied Behavior Analysis (ABA) services, as well as others. In addition, our affiliate Carelon MBM provides a comprehensive group of physician specialists for their scope of reviews. If we cannot match a specialty or subspecialty internally, we can coordinate with our affiliated external vendor who can provide the specialty and a determination within the turnaround time of the request.

If the licensed specialist is located outside of the State, our Kansas-licensed Medical Director or Pharmacist will attest the peer reviewer's decision upon receipt, since determinations can only be rendered by a Kansas-licensed provider. This ensures there is consistency in application of State-specific guidelines and criteria for the Member's particular needs, as well as the specialized knowledge so they receive the most appropriate level of care. In addition, if we identify the need for a recurring type of peer physician that we do not have on staff internally or with our affiliated external vendor, we will begin taking steps to do so.

If an appeal is filed by a Member or a Provider on behalf of the Member, Healthy Blue will continue to use the same strategy to ensure the most appropriate determination is rendered, as we recognize the impact these decisions have on a Member's health journey. Healthy Blue adheres to NCQA and State requirements and understands that the involvement of a professional within the same field leads to a fair, accurate and comprehensive review of the circumstances related to the appeal.

Perspective can often be gained through collaboration, and individual cases have facets that may only be revealed when examined from a variety of perspectives. This underlines the importance of ensuring that Providers can consult and collaborate with a peer so that the best outcome for the Member is ultimately achieved.

Q.11. Please elaborate on how you will contribute to and support the state in creating and publishing a timely and user-friendly dashboard of meaningful metrics for members and stakeholders of the Medicaid program.

A.11.

Collaborating with the State on a Meaningful Medicaid Dashboard

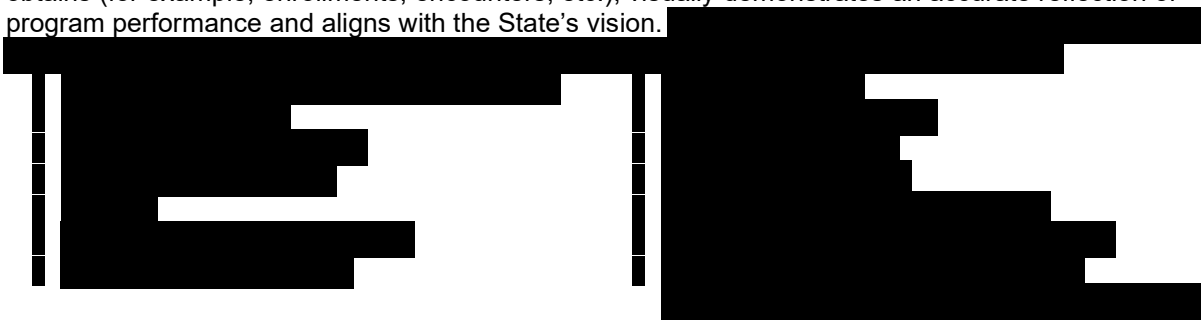
Healthy Blue is committed to collaborating with, contributing to, and supporting the Kansas Department of Health and Environment (KDHE) and Kansas Department of Aging and Disability Services (KDADS) in creating and publishing a timely, user-friendly dashboard of meaningful metrics for Members and stakeholders that aligns with the State's vision. We bring the experience and expertise from our affiliate health plans who have partnered with State agencies, Members, community-based organizations (CBOs), Providers, and other Managed Care Organizations (MCOs) to develop and maintain dashboards that focus on a variety of goals and objectives. [redacted]

To achieve a meaningful dashboard for Members and stakeholders, we recommend an open line of communication amongst the State, stakeholders, and MCOs during the project planning phase through project completion. [redacted] In recent years, we have found that the transition to timely dashboards is extremely helpful for Members and stakeholders to drive conversations and inform decisions that affect the health and well-being of themselves and their communities. We have the technology and processes to contribute to and support the State in creating such a dashboard. In addition, we have multiple channels focused on stakeholder communications and feedback that we can leverage in the build-out and promotion of the dashboard upon completion.

Iowa is a great example of how the State, MCOs, and stakeholders came together to produce a dashboard that is user-friendly while including a vast amount of data and information. The dashboard includes summaries and reports that span from quality scores to Home- and Community-Based Services (HCBS) participant experience survey results, to appeals, to program outcomes. [redacted] The dashboard is updated quarterly.

[redacted]

Metric Development. The backbone of a meaningful dashboard is the accuracy and timeliness of data. Healthy Blue will provide information and data that, when combined with data that the State already obtains (for example, enrollments, encounters, etc.), visually demonstrates an accurate reflection of program performance and aligns with the State's vision.



CQI and Feedback Loops. MCOs are in the unique position to interact with Members and stakeholders every single day. As with any program Healthy Blue implements, we will implement a CQI approach to the dashboard by gathering feedback on the use, effectiveness, and design of the dashboard. Any suggested recommendations and enhancements will be brought to the workgroup for consideration in future iterations.

In conclusion, Healthy Blue is committed to supporting the State's vision to create and publish a user-friendly and timely dashboard. By using our collective robust data analysis and innovative capabilities, we will be able to deliver valuable insights to Members and stakeholders of the Medicaid program.

Q.12. Noncompliance reported in your bid response noted areas where a pattern of issues occurred with the timeliness and accuracy of encounter submissions. Please elaborate on changes you have recently made to improve in this area.

A.12.

[redacted]

When considering the pattern of Encounters issues, it is important to understand that despite supporting more than 22 states plus DC and Puerto Rico, more than 50% of the reported issues have come from the state of Kentucky. As mentioned, Kentucky measures performance against a standard of 100% for both timeliness and accuracy — a standard that results in every Managed Care Organization (MCO) being evaluated as noncompliant each month. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Our organization has shown a strong commitment to improving the timeliness and accuracy of Encounter submissions.

[redacted]

Q.13. Please elaborate on how you remedied the transportation issues experienced in Louisiana.

A.13.

After evaluating the non-emergency medical transportation (NEMT) challenges encountered in Louisiana, we discerned that most of the issues involved late or missed trips. We are aware of the substantial impact this has on the Member, and accordingly, we allied with our transportation vendor and our Vendor Strategy and Oversight (VSO) team, along with Healthy Blue, to address and resolve these transportation complications.

After working together on potential solutions, our vendor took actionable steps based on what we agreed was needed to improve the experience for Members. We will apply the insights gained from Louisiana and the 14 other markets where we currently manage NEMT, as we implement a strong transportation benefit for Kansas.

Resolving and Mitigating Late and Missed Trips in Louisiana

[redacted]

Remediating Non-Trip Issues in Louisiana

To remediate non-trip issues the NEMT vendor experienced in Louisiana, our organization increased vendor oversight and monitoring, opened corrective action plans (CAPs) when appropriate, re-educated the NEMT vendor on required service levels, and collaborated across internal Operations teams, so they could monitor for incomplete data or service anomalies. These issues are detailed in Table 13-1:

[redacted]

[redacted]

Facility Liaison Will Support Reliable, Accessible Transportation Services

[redacted]

Healthy Blue recognizes the vital role NEMT services play in helping Members efficiently access medically necessary care. Having access to reliable transportation enables Members to receive the right care at the right place from their Provider of choice. To meet their individual needs, Healthy Blue will monitor the availability and timeliness of NEMT services, in accordance with State Access standards, including Members in Rural and frontier areas. We will leverage our organization's national experience and expertise to work with our NEMT vendor to meet or exceed contract requirements. Our NEMT approach demonstrates our understanding of the unique challenges associated with providing reliable transportation to Kansans and our innovative NEMT solutions to overcoming these challenges through compliance, education, and oversight.

Q.14. Prior authorization difficulties are a common theme amongst Medicaid stakeholders. Please elaborate on the top 2-3 items that you are focused on related to improving the Prior Authorization Process, including changes you feel the state could make to help you achieve your goals.

A.14.

How Healthy Blue is Focused on Improving the Prior Authorization Process

For health plans, manual Prior Authorization (PA) processes add administrative costs and can cause delays in needed care, creating frustration for all stakeholders. 75% of physicians surveyed by the American Medical Association describe the PA process as burdensome. Healthy Blue is committed to improving the Provider's experience and streamlining the Prior Authorization process, while assuring Member treatment is safe, medically necessary, high-quality, and appropriate.

Our strategy to improve PAs prioritizes the following three solutions: 1) make changes to our systems to improve efficiency and reduce turnaround times (TATs), 2) decrease the need for PAs, and 3) when a PA is needed, simplifying and streamlining our process to fit within the Provider's current workflow.

Solution 1: Internal Improvements

PA is a complex determination that evaluates medical necessity against State and health plan guidelines, coupled with a member's medical record. We use technology to streamline our internal PA processes by using real-time information exchange and Artificial Intelligence (AI) workflow improvements to support Providers and our staff and improve TAT.

Intelligent Clinical Assist (ICA), our patent-pending Artificial intelligence (AI) engine provides increased efficiency and quicker PA approvals by automating the identification of medically necessary information. 78% of PA submissions can be resolved by AI with no human intervention, using our ICA tool. For those PAs requiring intervention, ICA uses Optical Care Recognition to process medical records to query, identify, and display medical necessity criteria to our Utilization Management (UM) clinicians, speeding up the approval process and reducing the need to suspend authorizations due to missing information.

Our Virtual Nurse On-site (VNO) EHR Access program optimizes inpatient UM reviews by providing our UM Clinicians with direct electronic health record (HER) access to a facility's EHR portal. VNO reduces denials for lack of information and the need for appeals, improving continuity of care and more accurately risk stratifying Members. Affiliate health plans that have deployed VNO have reduced lack of information prior authorization denials by 96%. This workflow improvement reduces the need for manual processes with our Provider partners and supports quicker TAT for inpatient UM reviews.

Provider partners with full EHR connectivity to our Provider portal have seen average TATs reduced from 2.5 days to as short as 90 seconds through deployment of these automated internal tools. Our first strategy for improving PA will continue to be streamlining our internal processes and encouraging Providers to leverage those improvements with a growing list of compatible EHR solutions.

Solution 2: Reducing the Need for Prior Authorizations

Recognizing the level of effort needed to determine if a PA is required not only increases the burden on Providers but the administrative cost for health plans and Providers alike. We use several focused methods to decrease this effort.

Removing Prior Authorization Requirements

We have reduced the PA requirements on more than 1000 current CPT® codes over the last three years. This review process is done at least semi-annually and more frequently if necessary. As we determine it is clinically safe to remove PA restrictions, we will share our findings with the State to discuss our rationale and potential applicability for broader adoption by other Managed Care Organizations (MCOs).

Gold Card

We have a program for certain high-performance care Providers called the Prior Authorization Pass (PA Pass), which waives PAs for approximately 400 outpatient procedure codes. Care Providers qualify for the program when they are in value-based payment agreements with our affiliate health plans and meet

specific performance criteria. The Prior Authorization Optimization (PAO) program, designed for smaller groups of care Providers, allows automatic and immediate authorization upon electronic authorization for approximately 250 outpatient procedure codes.

Prior Authorization Check

Our web portal, powered by Availity, enables Providers to check if an authorization is required before initiating a request. PA check substantially reduces the required staff time by avoiding unnecessary PAs Additionally, Healthy Blue is exploring the possibility of automating some medical necessity requirements to work within a Provider's EHRs and avoid the need to perform a full PA when requisite conditions are met. For example, smart edits in the pharmacy claims system bypasses the PA requirement for certain drugs through our use of intelligent and automated logic at the point of sale (POS) to check medical and pharmacy claims data to determine if a Member meets the PA criteria. If the medication meets medical necessity during this automated review, the PA edit is bypassed and the claim processes within seconds.

In Indiana, our affiliate has reduced the number of pharmacy PA submissions by 20% utilizing this new tool.

Solution 3: Simplifying the Process for our Provider Partners

Healthy Blue understands that solutions work best when they can be seamlessly inserted into Providers' current workflows. We meet Providers where they are, providing solutions that match their level of automation and EHR capabilities.

Currently, to seek a PA, a Provider must gather the patient information, create a PA request, forward the pertinent clinical information, complete a clinical survey, submit the PA request, and then monitor for a response from the health plan. Non-digital submissions like fax, mail, and phone calls compound the opportunity for human error and often result in delays and higher administrative costs for both parties. According to a survey by the Health Financial Management Association, the average manually submitted PA consumes 21 minutes of Provider staff time.

Healthy Blue simplifies the PA process for all Providers by using an integrated platform and tools that streamline the workflow and reduce the administrative burden. Providers can electronically submit PA requests via their EHR or our web portal tool. Health care Providers can also access real-time information on the status of their requests and receive automated notifications, reducing potential delays in patient care.

Additionally, our Provider portal also supports digital correspondence exchange, eliminating the need for manual follow up processes such as faxing and phone calls. The platform offers a Prior Authorization Dashboard designed to streamline the process, eliminate bottlenecks through real-time status updates, utilize automation, and substantially improve overall efficiency.

Even for our least sophisticated Providers, end-to-end staff time required for PAs is reduced from an average of 21 minutes for a manual submission to less than eight minutes when using our web-based PA portal.

Full EHR Integration. We recognize the PA process works best for Providers when it is integrated seamlessly into their workflows. This most fully occurs through EHR connectivity. This transforms Provider PA workflows and is vastly different than the industry approach of providing a PA tool to Providers which requires manual entry of non-clinical data. For Providers with limited or no access to an EHR, we will work with them through the solutions mentioned above to ensure that our workflows are efficient, effective, and reduce unnecessary administrative tasks.

As shown in Table 14-1, as Healthy Blue's Network Providers migrate from no EHR integration to full EHR integration using Healthy Blue's fully integrated PA tool, they move from a manual, process flow-interruption model with normal response times, to an automated, seamless process flow model with immediate response times in most cases. With early adopters of full EHR integration of our PA process, we see more than 50% of the PA submissions answered with "no authorization needed," streamlining time to treatment in thousands of Member cases.

Table 14-1. Process and response impact of integration of PA into the Provider's EHR.

PA Process Steps	No EHR Integration	Partial EHR Integration	Full EHR Integration
Initiate PA request	Provider uses Provider portal to create a PA request	Provider initiates PA request directly within their EHR	Provider initiates PA request directly within their EHR
Enter Member and Provider demographics and attestation information	Manual entry	Automated entry and submission	Automated entry and submission
Answer clinical questions	Manual entry of answers clinical questions in EHR	Manual entry of answers clinical questions in EHR	Automated extraction of clinical data from EHR
PA decision	Manual retrieval of PA decision and copies into EHR	Automated delivery of PA decision within EHR	Automated delivery of PA decision within EHR

When PA is fully integrated, Providers have seamless functionality, removing the need for attestation and manual data entry thus eliminating the administrative burden. The Provider's workflow is optimized through the elimination of manual processes. We can achieve real-time or near real-time authorization by leveraging structured data directly from the EHR and parsing unstructured data using natural language processing. Providers with full EHR integration are seeing end-to-end staff time reduced to four minutes per PA submission, with most submissions achieving approval TATs times of less than 90 seconds.

The strategies discussed above are being deployed and tailored for nearly all Providers; physical health, hospitals, pharmacies, LTSS and BH Providers. The strategies for each Provider type leverage technology, connectivity and streamlined workflows differently to achieve the shared goal to reduce administrative burdens, enhance the Provider experience and advance member outcomes.

Collaborating with the State to Achieve Goals of Improving the PA Process

A joint effort between Healthy Blue and the State is a critical component of enhancing the PA process to be more streamlined, efficient, and less burdensome for Providers. The State has a unique capacity to support and accelerate the adoption of best practices. Through a cooperative effort, we will reduce Provider administrative burden and further their ability to focus on improving Member outcomes. The State's involvement to catalyze improvements in the PA process could include:

- **Encouraging Adoption of EHRs.** One area where the State can assist is in the encouragement of EHR adoption among Providers. Given the potential financial and technical hurdles, especially for those serving marginalized communities, the State could offer implementation support or incentives reminiscent of the KDHE's EHR Incentive Program funded through CMS' Medicaid Promoting Interoperability "Meaningful Use" Program. This support could be instrumental in advancing Providers' technological capabilities, directly improving health care delivery and facilitating smoother PA processes.
- **Support CMS' Efforts Toward a Standardized API Framework by 1/1/2027.** CMS requires Medicaid Managed Care health plans to develop specific application programming interfaces (APIs) to improve the electronic exchange of health care data, as well as to streamline PA processes. CMS is encouraging Providers to adopt compatible electronic PA processes for Medicaid. Kansas should ensure any additional state requirements are consistent with the CMS Interoperability and Prior Authorization Final Rule requirements to facilitate the fullest and most efficient exchange of data.

- **Commitment to Open Communication.** Our collaborative philosophy emphasizes open, two-way communication and adaptability with the State and Providers. Quick feedback from the State regarding Provider frustrations allows us to address and mitigate issues promptly, preventing escalation. This responsive approach is foundational in reducing PA requirements and minimizing Provider abrasion.
- **Flexibility in Clinical Criteria.** The State's support in allowing more flexibility for certain clinical criteria, specifically State-required criteria that is not material or critical to an appropriate PA decision, could be particularly beneficial during periods of high-volume authorizations. These allowances would improve TATs and reduce Provider frustrations for routinely approved PAs. We are intensely focused on leveraging technology and streamlining workflow processes to reduce PA burdens and speed decision making. The State's assistance and advocacy can greatly amplify our efforts to refine the PA process, making it more adaptive to the needs of today's KanCare landscape.

Through concerted efforts in promoting compatible technological adoption, fostering open communication, and allowing procedural flexibility, we can accelerate our initiatives to improve the efficiency and reduce the burden of PA for Providers for the benefit of KanCare Members.