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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**27**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder ensured HIPAA compliance with regards to Maria. • Bidder provided connections and/or information for New Baby New Life, SNAP, WIC, Pyx Health app, and community resources. • Bidder ensured a Spanish speaking lactation specialist. • Bidder provided information regarding NEMT. • Bidder ensured translation services available at OB visit. • Bidder provided VABs including breast pump, healthy grocer card, Food Fresh Connect, diapers, and 30 community transport visits. • Bidder ensured HRA and depression screening. • Bidder provided Spanish line option for their call-in line. • Bidder completed warm transfer to Spanish speaking OB care coordinator. • Bidder provided member with information on 9-8-8 number. • Bidder utilized PRAPARE screening tool. • Bidder provided information on a caregiver tool kit. • Bidder linked member to Healthy Blue Employment Navigator. • Bidder mentioned EPSDT in terms of periodicity schedule. • Bidder's person-centered care plan states "I" instead of "she". • Bidder's care plan is easy to follow and descriptive. • Bidder indicated they will check in with member once a month. • Bidder indicated that member's high risk maternity care coordination had been re-stratified. • Bidder provided Community Resource Link. • Bidder indicated access coordination of same day OB/GYN visit.	Weaknesses were identified that can be easily overcome. • Bidder did not proceed with BH crisis follow-up with member. • Bidder minimally addressed baby's care. • Bidder did not mention doula or CHW services. • Bidder did not mention home visiting program. • Bidder did not address family planning and birth control. • Bidder did not give enough detail on housing supports. • Bidder did not demonstrate support to the member to navigate resources and referrals. • Bidder connected member to housing stability team, but no mention of referral to HUD coordinated entry or other federal housing subsidies that member may be eligible for. • Bidder did not indicate SMART goals. • Bidder did not indicate MCO care coordinator qualifications other than Spanish speaking. • Bidder did not indicate how provider choice was provided. • Bidder did not provide detailed information on updating service plan process.

General Notes

Rating

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**28**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder receives notification upon ED visit. • Bidder gives priority for the need of SUD and detox treatment. • Bidder completed HRA, high risk maternity assessment, and assessment for sexual and domestic abuse. • Bidder reviews members health history and does a risk assessment of ED and unplanned admissions. • Bidder provides member with a high-risk maternity care coordinator. • Bidder connects member with CCBHC for services and MAT evaluation. • Bidder connects member to New Baby New Life program. • Bidder utilizes ASAM criteria as part of SUD assessment. • Bidder mentions certified peer mentor. • Bidder mentions Mental Health Club House model. • Bidder connects member to Virtual Emotional Well-Being program. • Bidder provides information on getting a cellphone. • Bidder connects member to MindDoula app. • Bidder ensures member has transportation to CCBHC. • Bidder provides 30 roundtrip rides other than NEMT via VAB. • Bidder provides $100 for rideshare, gas, and public transportation. • Bidder indicates service plan includes relationship mapping for natural and informal supports. • Bidder indicates connection with Nourished Well: Food as Medicine.	Weaknesses were identified that can be easily overcome. • Bidder did not ensure if there were charges pending at the shelter. • Bidder did not verify evaluation on member injuries including head injury. • Bidder did not provide medication evaluation consideration due to member's pregnancy. • Bidder did not demonstrate understanding of ILOS in Kansas. • Bidder did not demonstrate cultural sensitivity in the bidder narrative. • Bidder did not provide continuity of care for member's OB care. • Bidder does not indicate SMART goals. • Bidder does not indicate how provider choice is offered. • Bidder does not detail MCO care coordinator credentials. • Bidder provides confusing response on substance use treatment. • Member is referred to AA, but there is no mention of alcohol use. Her drugs of choice are benzodiazepines and opioids. • Bidder does not verify member choice, only indicates specific timeframe (2 years) rather than actual need for community therapies. • Bidder provides a referral for employment through a national employment phone line. No referral for WORK/STEPs or other Kansas resources identified. • Bidder did not mention family planning or birth control.

- Bidder's care coordinator gives the member a walkthrough of the MCO website.
- Bidder made proper referral to Kansas Statewide Homeless Coalition HUD's Continuum of Care for a homelessness screen.
- Bidder's person-centered care plan uses "I" instead of "she".
- Bidder provided Concierge Care app.
- Bidder's emotional wellbeing program is guided by cognitive behavioral therapy (CBT) interventions.
- Care coordinator reaches out to ED to assist with discharge planning.
- Bidder connects member to the Resilience through Intervention, Support, and Education (RISE) program to assist with addressing SUD concerns.
- Bidder provides information regarding SNAP and WIC.
- Bidder provides $100 gift card for Fresh Food Connect and a $100 gift card for Healthy Grocery Card.
- Bidder provides information to member on a nurse, dietician, doula, lactation consultant, midwife, and neonatologist via Virtual Medical Practice for Prenatal and Postpartum program.
- Bidder discusses childcare options with member.
- Bidder provides VAB for diapers and other baby items.
- Bidder connects member to Nurse Family Partnership program.
- Bidder indicates Housing Flex Funds for deposit and rent; however, this is not allowed under CMS regulations as Medicaid funds cannot be utilized for room and board.

General Notes

Rating

3

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**29**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder indicates they established a relationship with member. • Bidder indicates ADL and IADL support needs. • Bidder indicates ongoing care for respiratory and medical follow-along. • Bidder indicates self-direct and agency direct with a choice for agency direct. • Bidder indicates coordination for remote college attendance through reasonable accommodation request. • Bidder indicates home delivered medically tailored meals. • Bidder indicates caregiver care coordination for hospice, home health, and respite. • Bidder confirmed advanced planning with grandma. • Bidder discussed/assisted with information on a special needs trust and ABLE account. • Bidder discussed VR, STEPS, and WORK/WorkingHealthy options with member. • Bidder had a discussion on how alternative options might require member to leave the IDD waiver. • Bidder discussed or recognized communication device needs. • Bidder discussed ability for member to drive/potential options for vehicular modification. • Bidder connected member to Living Well in the Community app that also provides a $50 gift card VAB for utilization. • Bidder provides $100 for rideshare, gas, and public transportation.	Weaknesses were identified that can be easily overcome. • Bidder does not indicate how home delivered medically tailored meals are funded. • Bidder does not indicate SMART goals. • It is unclear if bidder understands home modification funding in relation to ILOS versus waiver services. • Bidder does not indicate prior waiver services utilized/received. • Bidder does not indicate if member wants to attend class in-person after recovery. • Bidder does not indicate CDDO for options counseling and affiliate providers. • Bidder indicates CIL as a resource for caregiving needs; however, member selected agency direct services and the agency would provide a worker so it is unclear why the CIL would be involved. • Bidder did not address social supports and activities for this member. • Bidder did not provide detail about role of home health for risk of future infections, medication management, Oxygen. • Bidder does not provide care coordination for pulmonologist. • Bidder did not provide detailed response on member's assessed services including PERS as part of a safety plan and backup plan. • Bidder refers member to the Transition Age Youth program through VOC REHAB; however, he is ineligible due to age.

- Bidder provided peer support via Self-Advocates Coalition of Kansas (SACK).
- Bidder discussed multiple housing options including grandmother's house with member/grandmother.
- Bidder provided information/connection to SourceAbled app to help member with resume and other items to secure employment.
- Bidder connected member to MapHabit for neurocognitive support.
- Bidder connected grandmother to hospice care coordination services.
- Bidder acknowledged member's ability to access PCS waiver services.
- Bidder connected member to CareBridge for LTSS needs.
- Bidder used "I" instead of "he" in All About Me plan.
- Bidder held a face-to-face visit in the hospital during discharge planning process.
- Bidder begins discharge planning at admission and provides a discharge planning timeline.
- Bidder provided a referral to grief counseling.
- Bidder recognized they needed to provide simultaneous transition services for both grandmother and member.
- Bidder recognized there were immediate and short-term discharge planning needs, including servicing of wheelchair and personal care services, PT, homemaker, medical appointment follow-up, home delivered meals.
- Bidder discussed home modification needs.
- Bidder connected member with smart technologies for tablet.

General Notes

Rating

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**30**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder meets with member in person at SNF for discharge planning. • Bidder used minimum data set (MDS) to guide treatment planning. • Bidder utilized MapHabit program. • Bidder verified ROI was signed for family. • Bidder provided Peer to Peer evidence-based practice model. • Bidder provided referral to BI waiver and LTSS planning. • Bidder facilitated access to Pyx Health app with 24/7 365-day support. • Bidder created a safety plan prior to discharge. • Bidder provided a timeline for monitoring after discharge. • Bidder reported the use of a program call Nymbl specific to fall prevention. • Bidder reports experience transitioning members from facilities to the community. • Bidder completed HRA and HSA for member. • Bidder completes neurobehavioral assessment, as well as routine screenings for depression, suicide, and post-traumatic stress risks as recommended by SAMHSA. • Bidder connects member to The Whole Person organization with brain injury peer support group. Bidder also connected member to BI Association of Kansas and Kansas City support groups. • Bidder connects member with VABs Fresh Food Connect and non-NEMT transportation.	Weaknesses were identified that can be easily overcome. • Bidder provided nursing facility as main point of contact for transition planning. • Bidder chose to connect member to podcasts and movies for loneliness. • Bidder did not discuss WORK/WorkingHealthy with the member prior to employment. Bidder did not discuss STEPs with the member. Bidder did not discuss potential Medicaid and Social Security entitlement eligibility impact of employment prior to member becoming employed. • Bidder indicated that under ILOS they would arrange for PCS until waiver and appropriate services assessments occurred. • Bidder indicated community navigator as an ILOS. • Bidder did not make a recommendation for urology consult for incontinence issues. • Bidder did not provide detailed information for member's daily support needs including ADLs. • Bidder does not discuss institutional transition process in response, which would lead to a delay in coding for the member and cause a delay in services. The referral for BI waiver was sent to ADRC rather than following state institutional transition policy. • Bidder indicates connection to ADRC for MFP, but ADRC does not provide MFP. • Bidder's indication of community navigator contract is unclear. • Bidder does not indicate MCO care coordinator qualifications.

- Bidder trains care coordinators in charting the LifeCourse concepts.
- Bidder connects member with LifeWise to assess for home modifications.
- Bidder connects member to SourceAbled Employment Navigator.
- Bidder addressed the process of working with the facility with a quality-of-care concern such as a pressure ulcer.
- Bidder assigned member to Healthy Blue transition specialist.
- Bidder was conscientious with member's discharge needs.
- Bidder utilized their integrated Health Insight Platform (HIP) to document and track activities involved in supporting member.
- Bidder ensured NEMT transportation for scheduled appointments to PCP, neurologist, dentist, and therapist.
- Bidder connected with licensed therapist affiliated with PCP.
- Bidder gave member option of self-direct versus agency directed.
- Bidder addressed short- and long-term discharge goals.
- Bidder provided options for in home and out of home therapies.
- Bidder provided specialized mattress for member upon discharge.
- Bidder ensured home delivered meals for member.
- Bidder indicates level III care coordination for member.
- Bidder indicates discharge from the nursing facility into the "most inclusive setting".

- Bidder does not indicate SMART goals.
- Bidder does not indicate informed choice for waiver provider services.
- Bidder does not indicate pressure ulcer report to the State via AIRS.
- Bidder indicates "caregiver support through KDADS" without explaining what is meant.

General Notes

Rating

3

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**31**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
• Bidder MCO care coordinator conducts assessments for HSA, HRA, BH, SUD, and SDOH. Bidder indicated that the HRA was completed in-person. • Bidder indicates use of GAINS reentry checklist. • Bidder aligned with KDOC to avoid duplication of services. Bidder indicates access to KDOC resources post-release. • Bidder indicates permanent housing goal set for 30- to 60-days after release. • Bidder indicates use of Housing Stability program. • Bidder indicates use of VAB for Identification Support, Fresh Food Connect, non-NEMT transportation support (30-round trips), and transportation essentials. • Bidder indicates smartphone provided with VAB health apps loaded. • Bidder indicates access to RISE program. • Bidder indicates assistance in applying for Federal Bonding Program. • Bidder reported that member would have to reapply for Medicaid due to length of incarceration. • Bidder had a realistic understanding that there may be the potential for setbacks and connected with certified peer support specialist, formed support plan, and informed of 9-8-8 number. • Bidder connected member to Mindoula which addresses BH and SDOH needs.	The response is minimally acceptable. • Bidder does not indicate timeframe of engagement but states "engagement begins prior to release when possible". • Bidder does not indicate SMART goals. • Bidder's response lacks details regarding the informed choice process. • Bidder does not indicate MCO care coordinator qualifications, only that member received care coordinator's biography. • Bidder did not discuss STEPs with the member prior to employment. Bidder did not discuss potential Medicaid and Social Security entitlement eligibility impact of employment prior to member becoming employed. • Bidder's response lacked details in helping member with social supports in member goal of repairing family relationships. • Bidder did not mention CHW support. • Bidder did not recognize need for family planning or birth control details for member. • Bidder provided member with limited choice for healthcare and behavioral healthcare providers. • Bidder discussed certified SOAR worker being utilized to assist with Social Security application, which would have had to be completed prior to Medicaid application being submitted from Topeka Correctional Facility team. • Bidder indicates use of Housing Flex Fund as payment for rent; however, Medicaid dollars cannot be used for room and board.

- Bidder connected member with Healthy Blue Employment Stability Team.
- Bidder connected member to CCBHC.
- Bidder provided referral to Workforce Innovation Opportunity Act (WIOA).
- Bidder offered connection to CBT and Emotional WellBeing app.

- Bidder did not ensure that Mary actually initiated her social security benefits. Therefore, Mary could be at risk of losing her Medicaid coverage after 90 days.
- Bidder indicated that care coordinator shared personal interests with member prior to release. State considers this a safety concern.
- Bidder lacked detail on housing plans after transitional housing placement.
- Bidder did not indicate how housing choice was provided to member.
- While it could be assumed that the individual was assisted with connection to HUDs Coordinated Entry program through the Housing Specialist, that was not identified in the response. It is important that all eligible individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services and supports that will assist the individual with residing independently in the community.
- Bidder mentions financial investment in Kansas Statewide Homeless Coalition and United Way of the Plains but lacks detail on what the investment is or how it benefits members. Especially for this member, because both organizations would not cover the Topeka area.
- Bidder does not provide detailed information on specific services or processes for how services will be received.
- Bidder did not indicate choice of community chosen by member post release, which would have driven her CCBHC choices and all other resources.

General Notes

Rating

2

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	**32**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder ensured environmental assessment was completed. • Bidder connected member/family with an allergist, which resulted in a medication change. • Bidder connected member to Kansas Youth Empowerment Academy and their Kansas Youth Leadership Forum. • Bidder reports connecting member to Transition Aged Youth Homelessness Prevention Seminar Series. • Bidder provided information on and connection to DCF's Independent Living Program. • Bidder verified member interests to be able to connect to appropriate supports. • Bidder provided VAB of $100 for Youth Club membership. • Bidder "models" Children's Home Asthma Management Program (CHAMPS) to assist with reducing asthma related ED visits. • Bidder indicates trauma informed approach with member. • Bidder indicates drug screen by PCP. • Bidder indicates use of Charting the LifeCourse Tools. • Bidder indicates culturally aligned CHW. • Bidder connected member with 4H with a peer mentor. • Bidder indicates in-home CHW visit. • Bidder reported utilizing Moving Toward Equity in Asthma Care, offered through the Healthy Blue Provider portal. • Bidder provides clear process for care coordination roles and who will be taking what steps.	Weaknesses were identified that can be easily overcome. • Bidder did not discuss potential SED waiver option. • Bidder did not discuss utilization of EPSDT program and services. • Bidder did not provide any caregiver assistance for foster family. • Bidder indicates MCO care coordinator qualifications as "fully trained in behavioral health care coordination" without further explanation of what is meant. • Bidder does not indicate SMART goals. • Bidder does not indicate a stratification of risk. • Bidder did not indicate the DCF case management provider (legal guardian) in meetings or planning. • Bidder did not indicate how informed choice process was provided. • Bidder provided CAGE questionnaire to PCP, yet alcohol misuse or abuse was not indicated. • Bidder did not address culturally competent care with the exception of a culturally aligned CHW. • Bidder did not complete HRA or HSA.

- Bidder uses “I” instead of “he” in person centered treatment plan.
- Bidder verifies Screening, Brief Intervention, and Referral to Treatment (SBIRT) completed by provider.
- Bidder indicated they use a whole-person centered approach.
- Bidder provided member’s PCP with several assessment tools. The PCP chose Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) for adolescent drug and alcohol screening.
- Bidder recognized that asthma could bring anxiety, so they provided member’s PCP with tools for an anxiety assessment. PCP utilized Screen for Child Anxiety Related Disorders (SCARED) and discovered member’s anxiety scores were low.
- Bidder connected with the school and informed the school nurse when a new asthma management plan was developed.
- Bidder made a referral to Developing Caring Communities Committed to Action (DCCCA) to assist the foster parents with member’s new PCSP and self-management initiatives.

General Notes

Rating

3

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

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

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

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

Response Considerations

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

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

Bidder Name	Question Number
Healthy Blue	33

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
The response is good. • Bidder did discuss options of family preservation and Disability Rights Center. • Bidder connected Member to CCBHC. • Bidder indicated knowledge of Electronic Visit Verification (EVV) process. • Bidder connected member to services for PBS, BH, PH, and ensured neuropsych testing. • Bidder provided caregiver training and supports. • Bidder ensured connection with dental provider. • Bidder connected Member and family to family therapy to assist with trauma. • Bidder provided VAB for headphones. • Bidder indicates MCO BH care coordinator added to team with credentials as a Master of Social Work, 8+ years working with conflicts/BH needs and experience with youth with complex needs. • Bidder indicated a speech language therapist review for potential communication device. • Bidder indicated connection to The ARC, Families Together, and local Special Education as parent supports. • Bidder indicates Awake Labs smart watch to monitor Member's stress levels. • Bidder initiated discharge planning within 24 hours of admission. • Bidder uses "I" instead of "he" in person centered treatment plan.	Weaknesses were identified that can be easily overcome. • Bidder lacks understanding of PRTF process: Bidder does not provide indication of approval from Member's mother for any specific PRTF. Bidder does not indicate going through PRTF process for approval with the state. Additionally, Bidder indicates a "200 mile search" for PRTF facilities, however, this may exceed state boundaries as all in-state providers must be exhausted first. Also, Bidder's timeline of 6 days for admission to PRTF is not realistic and bidder did not indicate a contingency plan. Finally, Bidder indicated placement in PRTF without exhausting all community resources. • Bidder does not indicate use of EPSDT and services, for example, the Communication device. • Bidder does not indicate an application to Parsons DDTTS. • Bidder does not indicate timelines for parent training for behavior management. • Bidder does not indicate a reasonable expectation of IDD waiver eligibility process, including crisis access to waiver services. • Bidder does not indicate a stratified risk assignment. • Bidder does not demonstrate a full understanding of Kansas ILOS. • Bidder uses ILOS frequently and inappropriately. Bidder does not demonstrate understanding of the hierarchy of funding measures in Kansas. For example, MapHabit and respite services. • Bidder does not indicate the CDDO for options counseling and affiliate providers.

- Bidder authorized additional stay and facilitated additional evaluations for the hospital to provide, including assessment of medication interactions, addressing Member's nonverbal status, and puberty-related support needs.
- Bidder explored potential for intensive outpatient treatment and/or partial hospitalization.
- Bidder described the need to update the plan of care.
- Bidder demonstrated understanding of ATK with regard to technology the member might need. Member received a loaner iPad device with specialized software, with indication of intent to purchase for Member.
- Bidder connected member and family to MapHabit and Care Bridges.
- Bidder described an integrated care team approach, including a Developmental Pediatric Medical Director.

- Bidder indicates regular monitoring but does not define the term "regular".
- Bidder does not detail the services Member received prior to most recent psychiatric inpatient stay.
- Bidder did not mention use of home risk assessment.
- Bidder did not indicate SMART goals.

General Notes

Rating

3

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

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

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

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

Response Considerations

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

Bidder Name	Question Number
Healthy Blue	**34**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
• Bidder described a provider service center to facilitate provider advocacy on behalf of members. • Bidder performed a HIPAA validation for the PCP related to the Member. • Bidder described understanding there could be an ABA benefit even without a definitive autism diagnosis. • Bidder did a warm transfer from the PCP phone call to the care coordination team. • Bidder facilitated HRA in person. • Bidder facilitated ABA services via telemedicine. • Bidder explained requirements of EPSDT to parents. • Bidder described use of the Health Insight platform to help develop the PCSP. • Bidder described making a referral to Autism Waiver. • Bidder referred Member for OT and speech language assessments, as well as Families Together, Kansas Family Support Center for caregiver training, and provided access to caregiver toolkits. • Bidder described an ABA quality incentive program specific to ABA providers. • Bidder assisted Alice's family in approaching Wiley Elementary School about their preschool program. MCO care coordinator experienced with IDEA Act and familiar with KS Dept of Education resources and services for Alice.	The response is minimally acceptable. • Bidder response lacks understanding of autism waiver application process, and timeline for when the Member would get off the proposed recipient list. Bidder continuously refers to Autism Waiver as the Autism Spectrum Disorder (ASD) Waiver. • Bidder did not provide detail regarding any rule out of hearing or neurological conditions. • Bidder does not clearly define care coordinator's qualifications. • Bidder does not provide sufficient information for determining stratification of risk. • Bidder does not indicate understanding of the function of the CDDO in developmental disabilities and functional assessments specific to IDD waiver. • Bidder does not provide autismspeaks.org as a resource. • Bidder does not indicate SMART goals. • While bidder does indicate ABA therapy will be provided remotely, there was no choice of provider discussed with family, nor was there discussion of ABA providers near member's location. Bidder did not indicate discussion with provider contracting to look at adding additional ABA providers to their network. • While bidder does describe the requirements of EPSDT to the family, no other discussion regarding EPSDT services occurs. • Bidder does not provide any specific service providers for services listed/discussed, including OT and ST, or include timeframes for services.

- Bidder provided VAB options that might be helpful for family to consider, including door alarm and gift card for OTC personal care items.
- Bidder connected providers to KS KidsMAP ECHO.
- Bidder completed SDOH assessment.
- Bidder connected family to Sensory Solutions Program.
- Bidder indicated Dental Desensitization Kit.
- Bidder facilitated access to digital library membership/e-reader.
- Bidder indicated confirmation of autism diagnosis prior to autism waiver referral.
- Bidder mentioned care in least restrictive environment.

- Bidder did not describe a certified SOAR worker referral, which could have been helpful in connecting Alice to additional Social Security benefits she may be entitled to.

General Notes

Rating

2

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

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

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

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

Bidder Name	Question Number
Healthy Blue	**36**

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
• Bidder indicates care coordinator assignment to an RN who has experience in chronic conditions and dual eligibility. Care coordinator bio was also provided to Member. • Bidder clarified with member that due to her hearing difficulty, she preferred emailed information. • Bidder indicates hearing evaluation and transportation scheduled. • Bidder indicated use of Healthy Blue dietician and healthy meals related to kidney disease and lowering blood pressure. • Bidder indicates access to PhonePal volunteers who speak on the phone to older adults to combat loneliness. • Bidder provided connection to American Association of Kidney Patients through Community Resource Link (CRL). • Bidder does indicate Medicaid is payer of last resort. • Bidder provides captioning smartphone apps. • Bidder ensures a special TTY phone. • Bidder ensures hearing aids provided. • Bidder pursues contracting with nephrologist and ensures continuation of care. • Bidder indicates connection with Health Information Exchange. • Bidder provided referral to audiologist for hearing and balance exam. • Bidder connects Member to NEMT. • Bidder used Medicare/Medicaid data to do predictive analysis. • Bidder completed HRA. • Person centered care plan uses “I” instead of “she” language.	The response is minimally acceptable. • Bidder does not indicate how stratification is done. • Bidder does not indicate provider choice. • Bidder does not indicate SMART goals. • Bidder indicates that initial face-to-face meeting may take up to 90 days. The State would prefer a shorter timeframe due to the complexity of the Member’s health conditions. • Bidder does not indicate any assessment of ADL/IADL support needs. • Bidder does not indicate a Frail Elderly waiver referral. • Bidder’s indication of “Everyday Essentials” is not clearly defined. • Bidder did not provide local resources for social supports and wellness activities. • Bidder did not provide a medication reminder tool. • Bidder’s response lacked detail on how depression was identified and how they would connect her to local resources. • Bidder indicates limited “one-way” transports for routine health and non-health transportation services. Bidder does not specify what “limited” entails. NEMT transportation would be covered under Medicaid medical benefits and are not limited. Non-NEMT transportation may be a VAB, but is not clearly defined in Bidder’s response. • Bidder did not detail how they would help the member meet her nutrition needs via the use of local resources. • Bidder did not define approaches for culturally competent care.

- Bidder reports 30 years of organizational experience coordinating Medicaid and Medicare plans.
- Bidder reports utilization of integrated care team.
- Bidder describes member flagged as dual eligible in their system.
- Bidder receives missed care alerts from their Health Insight Platform.

General Notes

Rating

2

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

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

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

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

Response Considerations

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

Bidder Name	Question Number
Healthy Blue	37

EVALUATOR NOTES	
Response Strengths	**Response Weaknesses**
• Bidder completed HRA, SDOH assessment, and needs assessments. • Bidder connected member to tribal liaison. • Bidder connected member to tribal social supports and counseling services. • Bidder stratified care at level 2 chronic conditions. • Bidder provided Member connection to digital mental health toolkit for app on phone. • Bidder secures appointments and transportation to attend appointments. • Bidder connects member to American Indian or Alaska Native (AI/AN) Community Health Representative (CHR). • Bidder indicates plan information was mailed. • Bidder indicates MCO care coordinator assigned with a specialty in chronic conditions, trained in AI/AN population. • Bidder indicates leveraging connections with the non-contracted IHCP to receive Admission, Discharge, and Transfer ADT files. • Bidder indicates referral to member for Special Diabetic Program for Indians (SDPI) grant by American Diabetes Association. • Bidder indicates VAB for transportation essentials, Fresh Food Connect, Healthy Adults Healthy Results, and Food as Medicine. • Bidder informs member of BH crisis via 988 line. • Bidder provided member with information on crisis line Healthy Blue offers. • Bidder provided talk therapy and recovery supports via telemedicine.	The response is minimally acceptable. • Bidder does not provide multiple choice options for mental health resources or diabetes care, for example the bidder did not mention the option of a CCBHC. • Bidder did not provide detail for STEPS program, nor did they discuss what employment could do to Medicaid coverage including termination or spend down. Bidder does not provide detailed information on employment assistance. • Bidder seems to leave navigation up to member to most local resources, knowing member is apathetic and struggling. • Bidder has check-ins with member but provides no purposeful care coordination to local resources and services. • Bidder did not indicate SMART goals. • Bidder indicates member interested in basketball and using the gym, but the provided service plan does not indicate these activities. • While it could be assumed that the individual was assisted with connection to HUDs Coordinated Entry program through the Housing Specialist, that was not identified in the response. It is important that all eligible individuals at Risk of Homelessness and those who are Homeless are referred to the local HUD Continuum of Care to ensure that individuals have access to necessary housing services and supports that will assist the individual with residing independently in the community.

- Bidder acknowledged member was overwhelmed and tried to accommodate that.
- Bidder acknowledged member wanted to have more control over his alcohol use, referred to AA and additional SUD supportive resources.
- Bidder described a connection to dental services.
- Bidder made connection for member to Mindoula.
- Bidder helped member apply for SNAP.
- Bidder reports connecting member to Healthy Blue housing specialist.

- Bidder reports Jason making progress toward his health goals, and then he begins to work on employment and housing. That is readiness, and that is not in line with KS evidence-based practice.
- Bidder did not identify process steps on how he obtained his apartment.
- Bidder did not provide financial and housing stability support services based on reported prior eviction.

General Notes

Rating

2