| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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."<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.11: Maternity Care Coordination<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.3: Provider Network Adequacy Standards<br>7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care<br>7.5.5: Provider Network Access Standards |

| RFP References | |
|---|---|
| 7.10: Member Services | 7.10.1: Member Services General Requirements<br>7.10.10: Customer Service Center – Member Assistance<br>7.10.11: Member Crisis Assistance<br>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<br>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?

| **Response Considerations** |
| --- |
| 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 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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **27** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| The response is very good.<br>• Bidder recognized there may be a potential BH crisis and facilitated a warm transfer to a clinician who is a BH triage nurse.<br>• Bidder assigned a Spanish speaking care coordinator. Bidder provided an RN with 4 years' experience of complex health conditions and a BA in education.<br>• Bidder involved member's mother per member's request as they proceeded with action steps.<br>• Bidder completed HRA and the Edinburgh Postnatal Depression Scale in-person and did stratification of risk. Bidder also completed needs assessment and SDOH.<br>• Bidder had a person-centered care philosophy.<br>• Bidder provided telemedicine options.<br>• Bidder routed member to a food bank.<br>• Bidder ensured OB/GYN, and pediatric appointment was scheduled and connected translation services for appointments.<br>• Bidder provided a culturally competent lactation support connection (Lactation for Latino Families) and a breast pump.<br>• Bidder assisted member in installing a car seat.<br>• Bidder indicated next day follow-up call for crisis identified situation.<br>• Bidder indicates SMART goals in plan, and the plan was translated into Spanish.<br>• Bidder indicates member was re-stratified to high-risk maternity. | Weaknesses were identified that can be easily overcome.<br>• Bidder indicates multiple "incentives" but does not indicate if these are VABs or how they're funded.<br>• Bidder lacks detail on EPSDT.<br>• Bidder does not provide outcome of BH assessment.<br>• Bidder does not address lack of maternity care coordination prior to this call by member's mother.<br>• Member's person-centered care plan indicated the member's intention to return back to college. Bidder's care coordinator indicated member was not ready to return to college, yet a readiness assessment was not completed.<br>• Bidder did not discuss STEPs with the member, nor did they discuss what employment could do to Medicaid coverage including termination or spend down.<br>• Bidder connected member to housing specialist, but no mention of referral to HUD coordinated entry or other federal housing subsidies that member may be eligible for. |

- Bidder indicates education and connection with multiple food resources, including Kansas Food Bank pantry partners, home delivered meals, and Kansas DoubleUp Food Bucks.
- Bidder indicates WellBaby completion incentives via gift cards.
- Bidder indicates NEMT setup plus training of member to learn to schedule own appointments.
- Bidder indicates care coordinator helps member apply for WIC and SNAP.
- Bidder educates member on access to home visiting programs.
- Bidder connected member to a Promotora (Spanish speaking CHW) with connection to community supports.
- Bidder connects member to YMCA classes for parent support groups.
- Bidder identified need for care coordinator for next 12-months postpartum with weekly follow-up and at least 1 monthly face to face visit.
- Bidder's person-centered care plan says "I" instead of "she".
- Bidder indicates a connection to Kansas Health Information Network (KHIN) to receive EHR.

**General Notes**

**Rating**

4

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.3.4: Value-Added Benefits |
| 7.4: Care Coordination | 7.4.1: Care Coordination Program Overview<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.11: Maternity Care Coordination<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.3: Provider Network Adequacy Standards<br>7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care |

| RFP References | |
|---|---|
| | 7.5.5: Provider Network Access Standards<br>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<br>3.0: SUD Services<br>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;<br>ix. Identifying and addressing the member's SDOH needs, including assistance with obtaining housing, nutritional food, transportation, and employment;<br>x. Offering value-added services to the member (e.g., doulas, peer support, maternal home visits, contingency management);<br>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<br>xii. Providing member prenatal education (one to one education, birthing and parenting classes, breastfeeding, neonatal abstinence syndrome)?<br>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?<br>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?<br>12. Does the response describe how the bidder will continue to engage the member to consistently engage in treatment?<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **28** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| The response is very good.<br>• Bidder recognizes American Society of Addiction Medicine (ASAM) criteria utilizing domains to determine need and level of care for SUD placement.<br>• Bidder indicates use of Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool for SDOH as well as a C-SSR screen for suicidality.<br>• Bidder provides two options specific to pregnant/parenting women with rapid residential admission options.<br>• Bidder indicates use of Substance Abuse and Mental Health Services Administration (SAMHSA) trauma informed approach.<br>• Bidder indicates multiple VABs, including pregnancy rewards, a NICU support kit, SafeSleep program, and home delivered meals.<br>• Bidder indicates providing a phone with apps loaded, unlimited data, voice, and text.<br>• Bidder indicates assignment of high-risk OB care coordinator, an RN with experience in co-occurring BH for level III high-risk maternity.<br>• Bidder shared a care coordination portal to share information with other providers.<br>• Bidder identified need to update assessment due to inconsistencies regarding schizo-affective and bipolar disorder diagnosis.<br>• Bidder provided a referral to a CCBHC ACT team. | Weaknesses were identified that can be easily overcome.<br>• Bidder does not give enough detail for timeline on reconnecting with member.<br>• Bidder does not give many details on EPSDT.<br>• Bidder does not indicate SMART goals.<br>• Bidder does not address head and other injury outcomes from fight.<br>• It appears member is in Wichita, Kansas. Bidder indicates connecting with Kansas Statewide Homeless Coalition which does not cover Wichita.<br>• Bidder reports care coordinator “weaves in ASAM criteria screener”. That statement is confusing, as ASAM is an evidence-based assessment tool that requires following all domains to determine level of care for substance use/misuse disorder.<br>• Bidder connected member to housing specialist and reports referring individual to Public Housing Authority, but no mention of referral to HUDs coordinated entry system for individuals who are homeless or at risk of homelessness.<br>• Bidder indicated looking for step down supportive housing options such as a shelter for pregnant women. That does not align with Housing First. Member choice was limited after discharge from residential substance use treatment. |

- Bidder provides justice involvement support for the aftermath of the fight to ensure if charges are filed, the member would be aware and would be able to appear in court.
- Bidder indicates connection to KHIN for EHR. Bidder received ADT and ED alert triggers.
- Bidder provided detailed information on its FirstHand program which locates and connects/engages members. Bidder also detailed its plans to bring program to Kansas.
- Bidder has Molina on the Move program which allows member to get her HRA and BH assessment and CHW helped her complete it. Bidder houses a dedicated CHW in the program.
- Bidder explored reasons for member's disengagement with COMCARE.
- Bidder connected member to Healthy Moms Healthy Babies program. Bidder includes information for both pre- and post-partum care for both mom and baby.
- Bidder ensured there was a medication evaluation after reassessment of diagnoses and consideration of pregnancy.
- Bidder created a crisis, safety, and relapse prevention plan.
- Bidder provides Care Connections program which provides culturally competent education and postpartum services.
- Bidder connected member to doula services.
- Bidder provided dental services, including transportation to appointments.
- Bidder provides education on LARC.
- Bidder connected member to home visiting programs.

**General Notes**

**Rating**

4

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.3.2: Work Opportunities Reward Kansans (WORK) Program<br>7.3.3: Supports and Training for Employing People Successfully (STEPS)<br>7.3.4: Value-Added Benefits<br>7.3.5: In Lieu of Services |
| 7.4: Care Coordination | 7.4.1: Care Coordination Program Overview<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |

| RFP References | |
|---|---|
| 7.5: Provider Network | 7.5.3: Provider Network Adequacy Standards<br>7.5.5: Provider Network Access Standards<br>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<br>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** |
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| 8. Does the response describe how the bidder will ensure transition-related coordination and communication between the member's primary care provider and specialists?<br>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?<br>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:<br>i. Discussing the member's goals in more detail to understand his preferences (e.g., living arrangements, education, employment);<br>ii. Identifying other goals related to achieving independence (e.g., cooking, daily living skills, ability to use public transportation);<br>iii. Identifying the services and supports the member needs to assist him in achieving his goals;<br>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;<br>v. Identifying whether the member needs assistance with managing his finances or financial planning;<br>vi. Supporting the member's continued education and employment goals; and<br>vii. Identifying the need for social supports and activities?<br>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?<br>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?<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **29** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| • Bidder mentioned need for nursing services upon discharge.<br>• Bidder provided multiple VABs including respite, meals, and transport.<br>• Bidder discussed NEMT for appointments with the member.<br>• Bidder reported providing discharge planning at admission.<br>• Bidder utilized integrated care team.<br>• Bidder connected member's grandmother to bidder's Caregiver Supports program and other caregiver resources.<br>• Bidder indicates level III care coordination stratification.<br>• Bidder indicates weekly monitoring post-discharge for member.<br>• Bidder provided self-care education and training for member's grandmother.<br>• Bidder ensured PCP follow-up and transportation following hospital discharge. | The response is poor or unacceptable.<br>• Bidder did not discuss advanced planning with member or member's grandmother with consideration to grandmother's future health risks.<br>• Bidder does not indicate understanding of IDD system as CDDO would offer choice of affiliate providers.<br>• Bidder puts too much focus on TCM and needs to review TCM billing guidelines, as many items listed for TCM would not be able to be billed and would be the responsibility of the bidder. For example, bidder indicates numerous assessments that the TCM provides but not the care coordinator.<br>• Bidder does not mention PCS (other than passing mention of in-home supports).<br>• When bidder discusses residential, there is a lack of detail, and there is no discussion with the member on remaining in current setting. Per bidder response, member only indicates he wants to stay in the same community.<br>• Bidder does not discuss ABLE account or special needs trust.<br>• Bidder does not mention authorizations for therapies.<br>• Bidder mentions home modification with no discussion with the member. Bidder response shows lack of understanding on the funding of home modifications.<br>• Bidder indicates DME would be delivered but does not indicate what DME is going to be delivered and/or how this would benefit the member. |

- Bidder does not provide discussion on FMS/FEIN and agency direction. While self-direction is indicated, bidder has tied self-direction to employment and that self-direction is for individuals "who choose to self-direct certain services".
- Bidder does not detail definitive service options for this member. For example, bidder indicates support services may be required such as in-home nursing care, home modifications, and therapy services, but does not detail assessment for or utilization of said services. Bidder reported linking member to resources. Bidder did not indicate follow-up with member.
- Bidder discusses fall risk program with no indicators of fall history.
- Bidder mentions STEPs program, but member does not have appropriate diagnosis for this program. Bidder mentions employment supports but not as a waiver service. Bidder mentions vocational rehabilitation but does not tie it to potential waiver access for supported employment.
- Bidder did not mention updating HRA or HSA.
- Bidder response lacks detail connecting member with support groups.
- Bidder did not address SDOH needs.
- Bidder did not complete a mental health assessment.
- Bidder needed to describe and identify what local resources member was connected to.
- Bidder did not provide referral to member's grandmother for Frail Elderly waiver.
- Referral was needed for Center for Independent Living (CIL) to assist member with developing independent living skills as member's grandmother was primary support person.
- Bidder does not indicate SMART goals.
- Although bidder indicates assisted care that is not provided by member's grandmother, bidder does not detail how that care would happen.
- Bidder does not indicate MCO care coordinator qualifications.

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|---|---|
| | • Bidder indicates member has a behavioral support plan when no behavioral management support needs are indicated.<br>• Bidder did not adequately monitor member's physical health needs.<br>• Bidder did not definitively address member's need for grief counseling.<br>• While bidder discussed NEMT with the member, there was no discussion regarding mileage reimbursement or other travel options. |

**General Notes**

**Rating**

1

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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".<br><br>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.<br><br>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<br>7.3.3: Supports and Training for Employing People Successfully (STEPS)<br>7.3.4: Value-Added Benefits<br>7.3.5: In Lieu of Services |
| 7.4: Care Coordination | 7.4.1: Care Coordination Program Overview<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.3: Long-Term Services and Supports Functional Eligibility Determinations<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified populations<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.3: Provider Network Adequacy Standards<br>7.5.5: Provider Network Access Standards<br>7.5.7: Long-Term Services and Supports Provider Network Standards<br>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<br>4.0: Mental Health Services<br>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:<br>i. Discussing the member's long-term goals in more detail (e.g., return to work):<br>ii. Identifying other goals related to regaining his independence (e.g., cooking, daily living skills);<br>iii. Identifying the member's need for social supports and activities; and<br>iv. Identifying the services and supports the member needs to assist him in achieving his goals?<br>11. Does the response describe how the bidder will provide referrals for as identified in the POS/PCSP?<br>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?<br>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?<br>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?<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **30** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| • Bidder provides $5,000 in transition assistance.<br>• Bidder indicates level III care coordination stratification.<br>• Bidder determined home health need for visiting nurse for wound care.<br>• Bidder indicates authorization of BI waiver home delivered meals.<br>• Bidder indicated review of nursing facility chart, including PHQ-9 and utilization of MDS in developing person centered support plan.<br>• Bidder mentions VAB including vehicle modifications.<br>• Bidder connected member to support group through Brain Injury Association of Kansas and Greater Kansas City (BIAKGKC).<br>• Bidder was cognizant of medical needs including ST, PT, and OT.<br>• Bidder indicated choice counseling for providers.<br>• Bidder mentioned the potential ramifications of becoming employed for his Medicaid coverage.<br>• Bidder ensured member's providers were connected to bidder's provider portal to exchange information.<br>• Bidder reported respecting member's right to choose least restrictive environment.<br>• Bidder reported routinely assessing member's desire to discharge to the community through the utilization of an on-site nursing facility care coordinator. | The response is poor or unacceptable.<br>• Bidder did not mention HRA or HSA.<br>• Bidder did not follow-up on pressure ulcer. Bidder did not address quality of care issue with member's pressure ulcer. Bidder's response did not include reporting of member's pressure ulcer, which should have been reported as a potential NF quality of care issue deserving of follow-up.<br>• Bidder's response lacked detail around DME.<br>• Bidder lacked detail on assessment of depression. While bidder does indicate reviewing the PHQ-9, no detail was provided regarding treatment recommendations based on this assessment and member's report of feeling depressed.<br>• Bidder depends on Minds Matter for most healthcare and SDOH needs and coordination.<br>• Bidder did not indicate an updated assessment of ADL and IADL support needs prior to transition from nursing facility or once member returns to the community.<br>• Bidder does not indicate care coordinator qualifications.<br>• Bidder not only does not indicate SMART goals but indicates language such as "these goals may include".<br>• Bidder indicates neuropsych evaluation authorized "if appropriate" and provides no outcome or needs planning based on results of evaluation.<br>• Bidder does not show understanding of institutional transition. Bidder indicates transition planning and sending a "referral to |

ADRC 30-days pre-discharge". Bidder indicates completion of "BI eligibility attestation" for accessing waiver. 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.

- While bidder addresses they will provide $5,000 in transitional funds via a VAB, there is no mention of MFP or funding related to institutional transitions back into the community.
- Bidder does not provide specifics regarding services that would be included on the PCSP or discussion of backup plan.
- Bidder indicated Minds Matter would be providing home delivered meals. This is not a service they provide.
- Bidder indicates discussing with member who he would like included in his discussions of care, i.e., family, but never indicates any member chosen.
- Bidder indicates "home health services" but does not discuss PCS, Enhanced Care Services (ECS), or the option for self-direction or agency-direction.
- Bidder indicates that Minds Matter will continue to work on Transitional Living Skills (TLS), but it is not actually discussed that this is a waiver service.
- Bidder continually discusses a community care coordinator (CCC) and coordination that is not being initiated by Minds Matter is indicated to be initiated by the CCC, it does not appear in bidder's response that the bidder's care coordinator is providing any coordination.
- Bidder does not discuss authorization and timeframe for services.
- Bidder discusses setting up NEMT transport for the member while they are in the SNF. Transportation while in a SNF would be the responsibility of the facility. NEMT would only apply after discharge.
- Bidder lists PERS under transport.

| | |
|---|---|
| | • Bidder authorized weekly wound care. Without an assessment of the current wound stage, there is no indication that this frequency would meet the level of need for this member.<br>• Bidder did not refer member to urologist for incontinence.<br>• Bidder reported connecting to housing specialist, but there was no indication of what was done to ensure safe housing prior to discharge. It is unclear if the home he discharged to was assessed for habitability or safety.<br>• Bidder did not indicate if there was connection to a HUD continuum of care for assessment for any federal entitlement funding or supports that member may be eligible for upon discharge.<br>• Bidder's long-term follow-up planning does not indicate length of service and follow-up times.<br>• Bidder documents a collaborative decision between MCO care coordinator and CCC to move member from level III stratification to level II with no assessment indicated. |

**General Notes**

**Rating**

1

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.2: Network Development<br>7.5.3: Provider Network Adequacy Standards<br>7.5.5: Provider Network Access Standards<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **31** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| • Bidder connected member to VABs.<br>• Bidder completed HRA, HSA, BH assessments, and SMART goals. Bidder also scheduled a comprehensive BH assessment.<br>• Bidder connected member with justice system liaison who collaborates with KDOC.<br>• Bidder acknowledged SDOH needs.<br>• Bidder indicates level III stratification.<br>• Bidder indicates care coordinator assignment as BH licensed clinician with experience working with members involved in the criminal justice system.<br>• Bidder indicates identification of an interdisciplinarian team, including state parole.<br>• Bidder indicates TruConnect phone access loaded with MyMolina app and telehealth app.<br>• Bidder identified that they are the primary point of contact until CCBHC can come in at member's release.<br>• Bidder identified use of ASAM and WHODAS.<br>• Bidder connected member to Women's Network Path to Purpose program.<br>• Bidder indicates they would connect member with CCBHC in the area of the state she chose to be released to.<br>• Bidder arranged transportation with CCBHC to avoid gap in medication.<br>• Bidder discussed the potential for injectable versus oral medication. | The response is minimally acceptable.<br>• Bidder is vague about reentry barriers for member.<br>• Bidder did not give enough detail on SUD follow-up. Bidder's response does not indicate SUD supports.<br>• Bidder's response does not detail supports for material needs (e.g., clothing, permanent supportive housing needs).<br>• Bidder indicates member is "earning an independent income" but there is no documented discussion with member to advise how this may impact social security income and Medicaid benefits.<br>• Bidder's response does not indicate whether member has ADL or IADL support needs.<br>• Bidder does not indicate timeframe for member kit visit.<br>• Bidder does not define what past experiences care coordinator has with corrections.<br>• Bidder is vague on housing referrals. When member was released from incarceration, bidder placed member in "step down housing" through the Department of Corrections. It is unclear if member was provided housing choice.<br>• Bidder discusses connecting to housing specialist who works "behind the scenes if the member is eligible" for permanent supportive housing. This response indicates using SPMI to determine housing needs which is against ADA guidelines.<br>• While bidder indicates a stratification level III for this member, however, bidder also documents that KDOC determined member's |

- Bidder gave member a choice on providers.
- Bidder connected member with peer support.
- Bidder connected member with ClubHouse model.
- Bidder provided practice sessions for member to reconnect with family members.
- Bidder attempted to connect member with volunteer activities in areas of interest, especially when considering future employment opportunities.

level of need, i.e., stratification, and tells the bidder the services and supports member would need upon release.

- Bidder did not ensure that member actually initiated her social security benefits at the time of release. Therefore, member could be at risk of losing her Medicaid coverage after 90 days.
- Bidder did not discuss STEPs with the member, nor did they discuss what employment could do to Medicaid coverage including termination or spend down.

**General Notes**

**Rating**

2

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.9: Care Coordination Training Requirements<br>7.4.10: Requirements for Specified Populations<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.2: Network Development<br>7.5.3: Provider Network Adequacy Standards |

| RFP References | |
|---|---|
| | 7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care<br>7.5.5: Provider Network Access Standards<br>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<br>3.0: SUD Services<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **32** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| The response is good.<br>• Bidder assigned foster care case management.<br>• Bidder's CHW provided environmental scan of home. CHW has been trained to conduct environmental assessments by completing the standardized training, Healthy Home Principles and Assessment Practice for Health Educators and Community Workers through Children's Mercy Kansas City.<br>• Bidder provided a care coordination portal.<br>• Bidder discussed potential concerns about foster care aging out with the member.<br>• Bidder reviewed aging out transition plan developed when member was 16.<br>• Bidder connected member to MyHealth Asthma Disease Management Program.<br>• Bidder connected with member's school to make sure asthma plan was on file and an inhaler was made available.<br>• Bidder indicated they had a trauma informed BH provider.<br>• Bidder connected member with iFoster system that bidder is offering to eligible KanCare Members, which would give member information on obtaining a phone, computer, job programs, and financial resources.<br>• Bidder tried to ensure all providers were connected to Availity portal.<br>• Bidder talked to member's foster family and were exploring what member's potential asthma triggers are. | Weaknesses were identified that can be easily overcome.<br>• Bidder lacks understanding of home modification guidelines in Kansas.<br>• Bidder discussed Bidder's care coordinator and foster care CMP agreeing to a plan of service without member's input.<br>• Bidder discussed an education and training voucher stating member was eligible for 5 years or until age 26 but it was unclear who would fund it.<br>• Bidder reported use of ASAM "screener" but response is unclear on member's SUD status and level of care needed. ASAM is an assessment.<br>• Bidder does not provide detailed information on multiple providers or services. Bidder often indicates "if" or "may".<br>• Bidder does not connect member and/or foster family to CCBHC/CMHC. Bidder provided information but no connection indicated.<br>• Bidder does not indicate an ROI to discuss member's SUD information with others on his team.<br>• Bidder does not mention detail of completing HRA, HSA, or SDOH assessments.<br>• Bidder does not provide MCO care coordinator qualifications.<br>• Bidder does not indicate SMART goals.<br>• Bidder does not clearly indicate how care coordination is culturally aligned. |

- Bidder connected with pulmonologist and/or an asthma educator.
- Bidder provided support for foster family as well as connecting with Kansas Foster and Adoptive Family Association.
- Bidder assigned member to complex high-needs care coordination.
- Bidder reports the use of the PEDS QL and ASAM tool.
- Bidder discussed foster care transitions and whether member wanted to find any relatives.
- Bidder discussed with member about transitioning to a different counselor who was trauma informed and specialized in youth and discussed telemedicine or in person visits.
- Bidder connected member with BeMe online platform and discussed the existence of an BeMe adult platform.
- Bidder provided home visit schedule within 24-72 hours of PCP outreach.
- Bidder stated CHW will use the "Home Characteristics and Asthma Triggers—Training for Home Visitors" checklist developed by the CDC, EPA, and HUD.
- Bidder discussed with the family the need for using the exhaust fan and/or keeping windows open when cooking, routinely changing HVAC air filters, and using humidifier or dehumidifier to help with environmental triggers.
- Bidder provided a mattress and pillow covers as a VAB.
- Bidder ensured the AMR or asthma med ratio HEDIS measure to capture non-compliance with asthma medication.
- Bidder indicates care coordination portal alerts PCP and CMP of in-home visit.
- Bidder indicates interdisciplinary team includes CMP.

- Bidder's response lacks detail addressing member's concerns with aging out. Response also lacks detail regarding Kansas specific programs/services.

**General Notes**

**Rating**

3

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |

| RFP References | |
|---|---|
| 7.5: Provider Network | 7.5.2: Network Development<br>7.5.3: Provider Network Adequacy Standards<br>7.5.5: Provider Network Access Standards<br>7.5.7: Long-Term Services and Supports Provider Network Standards<br>7.5.8: Behavioral Health Provider Network Standards<br>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<br>4.0: Mental Health Services<br>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?<br>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?<br>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?<br>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:<br>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<br>ii. Arranging for in home supports, respite services, and crisis planning when the member returns to the home?<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **33** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| • Bidder connects mother to parental training supports.<br>• Bidder indicates consistent engagement with the family.<br>• Bidder indicates the MCO care coordinator starts discharge plan with team upon member's admittance to the hospital.<br>• Bidder indicates MCO care coordinator is a BH licensed clinician with IDD experience.<br>• Bidder indicates peer to peer case review between bidders' BH medical director and the inpatient psychiatrist at the facility.<br>• Bidder indicates TCARE, an evidence-based family caregiver burnout prevention solution that includes an assessment and plan.<br>• Bidder indicates Bidder's Peds QL assessment tool to gauge BH concerns. Bidder used PEDS QL at least quarterly to ensure his care plan reflects progress and any new challenges or barriers.<br>• Bidder indicates partnership between bidder, parent, Benchmark, CCBHC, and the school for BH support needs.<br>• Bidder indicates level III care coordination.<br>• Bidder indicates SED waiver referral.<br>• Bidder indicates intent to bring Roya Health to Kansas to open a new pediatric residential treatment center.<br>• Bidder authorized additional time for proper and safe discharge from the hospital.<br>• Bidder held a face-to-face meeting with mom.<br>• Bidder created a crisis safety plan and crisis debrief.<br>• Bidder involved family voice and choices. | The response is minimally acceptable.<br>• Bidder indicates TCM level of care. TCM's do not have levels.<br>• Bidder indicates hospital where member is located is in charge of placement options and locating placement. The MCO would be the main driver for this process; however, it would be collaborative with all involved parties.<br>• Bidder timeframe for admission to PRTF is unrealistic as PRTFs have waitlists.<br>• Bidder does not indicate exhausting all in state PRTFs (if approved) as all in state options would need to be exhausted prior to pursuing out of state options.<br>• Bidder does not indicate Parson's DDTTS involvement.<br>• Bidder response indicates a lack of understanding in PRTF process within the State of Kansas. For example, there is a requirement to demonstrate all community resources have been exhausted.<br>• Bidder does not discuss potential crisis exception for IDD waiver during discharge.<br>• Bidder indicates Benchmark providing services to the member while the member is in the PRTF. Outside services would not be provided to the member while they are in the PRTF by the bidder. Bidder's response does not take into consideration existing PBS contracts with some current PRTFs.<br>• Bidder does not indicate therapy discussion/provided for the rest of the family due to trauma family has incurred because of member's behaviors. |

- Bidder reviewed IEP and made sure the school was made aware of discharge.
- Bidder provided mother access to care coordination portal.

- Bidder indicates and provides “information on additional services” but does not indicate what additional services are being provided or discussed.
- Bidder does not indicate use of EPSDT.
- Bidder does not indicate connection with CDDO.
- Bidder does not indicate SMART goals.
- Bidder does not identify VABs in response.
- Bidder indicates stratification for level III care coordination is because member is “on the waitlist for the IDD HCBS waiver”.
- Bidder indicates CCBHC will assess for SED waiver; however, CMHCs are the contractor for that assessment.
- Bidder did not mention completion of HSA or HRA.
- Bidder did not mention home safety risk assessment.
- Bidder is unclear of understanding of Kansas ILOS with statement “wraparound supports ILOS”.
- Although bidder made a referral to the SED waiver, given the scenario, it should have been considered earlier.
- Bidder made an assumption on the availability of crisis stabilization units. This may be unrealistic. With potential long wait to admittance to PRTF, bidder does not address what services would need to be put in place to maintain safety if the member was brought home until they were able to be admitted.
- Bidder did not include DCF in a conversation with mother to address what may happen if mother puts member in state custody.
- Bidder did not provide detail on Kansas resources for this member.

**General Notes**

**Rating**

2

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5 2: Network Development<br>7.5.3: Provider Network Adequacy Standards<br>7.5.5: Provider Network Access Standards<br>7.5.8: Behavioral Health Provider Network Standards<br>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<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **34** |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| The response is good.<br>• Bidder indicates member is assigned to level II care coordination.<br>• Bidder uses Kansas Behavior Supports for telehealth ABA services.<br>• Bidder noted intent to utilize providers for ABA training and BH training via Research Units in Behavioral Intervention (RUBI).<br>• Bidder informed member's family of the benefits of OT and ST.<br>• Bidder gives member school options to Russell Child Development Center or Garfield Early Childhood Center within 15 minutes of Holcomb.<br>• Bidder educates family on family supports with TCARE.<br>• Bidder connects member's parents to Kansas Family Support Center.<br>• Bidder connects member's parents to Parents As Teachers program.<br>• Bidder confirms autism diagnosis and finds ABA provider for member.<br>• Bidder recognized there is an autism waiver in Kansas and helped family to apply.<br>• When Bidder was not able to answer provider query regarding ABA services, callback was provided.<br>• After bidder confirmed autism diagnosis, care coordinator provided basic information related to an ASD diagnosis including education on ABA therapy. He also explored details specific to member's behaviors.<br>• Bidder included family in person centered treatment plan. | Weaknesses were identified that can be easily overcome.<br>• Bidder lacks detail on addressing SDOH needs.<br>• Bidder does not mention completion of HRA or HSA.<br>• Bidder does not mention EPSDT services and assessments.<br>• Bidder did not provide detail regarding any rule out of hearing or neurological conditions.<br>• Bidder's response showed lack of understanding on the process for the autism waiver. Bidder's response indicates lack of autism waiver details such as proposed recipient list, timeframe of waiver access.<br>• Bidder does not identify incentives as VABs.<br>• Bidder indicates ABA access "as within a reasonable timeframe". Bidder does not indicate what is meant by reasonable timeframe.<br>• Bidder does not indicate SMART goals.<br>• Bidder does not indicate referral to SDSI CDDO for potential IDD services.<br>• Bidder indicates "additional waiver programs" but does not name what those programs could be.<br>• Bidder does not indicate MCO care coordinator qualifications.<br>• Bidder does not indicate how level II care coordination determination was derived.<br>• Bidder does not discuss NEMT and/or mileage reimbursement with family.<br>• While bidder indicates utilization of RUBI, there is not indication how this would be funded. |

- Bidder reported they would be providing ongoing support assistance in IEP planning.
- Bidder reported monthly follow-up; in person every 3 months.
- Bidder indicates MCO care coordinator as single point of contact.
- Bidder ensured connection with provider contracting due to lack of current providers in the area.

- Bidder is unclear regarding many services how and/or when they would be provided and who would be providing them.
- Bidder did not mention Autism Speaks as a resource.

**General Notes**

**Rating**

3

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.12: Care Transitions and Diversion Activities<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.2: Network Development<br>7.5.3: Provider Network Adequacy Standards<br>7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care<br>7.5.5: Provider Network Access Standards<br>7.5.7: Long-Term Services and Supports Provider Network Standards<br>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?<br>2. Does the response fully address all relevant RFP requirements and is the response consistent with the RFP?<br>3. Does the response align with KanCare's care coordination goals and objectives?<br>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)?<br>5. Does the response describe how the bidder will ensure the member's immediate needs are met?<br>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?<br>7. Does the response describe the bidder's approach to identifying and addressing health disparities for this member?<br>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)?<br>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?<br>10. Does the response describe how the bidder will determine the appropriate level of care coordination?<br>11. Does the response describe how the bidder will ensure the assigned care coordinator has appropriate qualifications relative to the member's health needs?<br>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?<br>13. Does the response describe how the bidder will utilize and share Medicare claims data to support care coordination?<br>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?<br>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<br>i. Allowing the member to continue to receive covered services from her current, non-participating Nephrologist to maintain continuity of care?<br>ii. Attempting to contract with the non-participating Nephrologist?<br>iii. Offering the member the option to be referred to an in-network Nephrologist?<br>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?<br>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?<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | **36** |

**EVALUATOR NOTES**

**Response Strengths**

- This evaluation group primarily considered a major weakness in that the bidder's response was only given from the Medicare side of the DSNP program, which impacted the evaluators' ability to properly evaluate the response from a Medicaid coverage perspective. Ultimately, this response has not met the Medicaid expectations and requirements of the RFP.
- Bidder noted coordination with the (Medicaid) KanCare coordinator to "leverage their expertise and resources" from both Medicare and Medicaid.
- The following strengths are only through the lens of Medicare:
  - Bidder provided communication across all insurance providers through the portal.
  - Bidder indicated in person face to face meetings.
  - Bidder discussed DSNP VABs with member.
  - Bidder referred to kidney support program.
  - Bidder used CHW.
  - Bidder educated member on hypertension.
  - Bidder screened member for loneliness and social isolation.
  - Bidder refers to audiologist and speech and language pathologist for testing and treatment.
  - Bidder assessed for BH needs.
  - Bidder connects member to Cedar House Food Bank.
  - Bidder indicates a single case agreement and contracting were pursued with out of network nephrologist.

**Response Weaknesses**

The response is poor or unacceptable.

- This evaluation group primarily considered a major weakness in that the bidder's response was only given from the Medicare side of the DSNP program, which impacted the evaluators' ability to properly evaluate the response from a Medicaid coverage perspective. Ultimately, this response has not met the Medicaid expectations and requirements of the RFP.
- The following weaknesses are only through the lens of Medicare:
  - Bidder's follow up with evaluation team is difficult to understand.
  - Bidder did not mention completion of HRA or HSA.
  - Bidder mentions SDOH by "any additional referral as needed".
  - Bidder needed to provide more detail on culturally competent care.
  - Bidder does not indicate SMART goals.
  - Bidder's response to services and processes was vague.
  - While bidder indicates they connect with the Medicaid/KanCare care coordinator, there is a lack of detail of benefit coverage between DSNP and Medicaid.
  - While bidder mentions LTSS in passing, there is not referral/connection to ADRC for FE waiver assessment.

- Bidder indicates NEMT and transportation education to member related to her goal of independence.
- Bidder details DSNP benefits such as hearing, assistive listening, patch cords, captioned phone systems, and phone amplification.

**General Notes**

**Rating**

1

| Bidder Name | Question Number | Topic Area | Evaluation Criteria |
|---|---|---|---|
| Molina Healthcare of Kansas, Inc. | **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.<br><br>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.<br><br>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.<br><br>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<br>7.4.2: Health Screens, Health Risk Assessments, and Needs Assessments<br>7.4.4: Plans of Service and Person-Centered Service Planning<br>7.4.5: Care Coordination Stratification Levels and Contact Schedules<br>7.4.6: Care Coordination Roles and Responsibilities<br>7.4.7: Qualifications for Care Coordinators<br>7.4.10: Requirements for Specified Populations<br>7.4.13: Social Determinants of Health<br>7.4.15: Electronic Care Management System |
| 7.5: Provider Network | 7.5.2: Network Development<br>7.5.3: Provider Network Adequacy Standards<br>7.5.4: Health Equity, Cultural Competency and Health Literacy in the Delivery of Care<br>7.5.5: Provider Network Access Standards |

| RFP References | |
|---|---|
| | 7.5.8: Behavioral Health Provider Network Standards<br>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<br>3.0: SUD Services<br>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 |
|---|---|
| Molina Healthcare of Kansas, Inc. | 37 |

| EVALUATOR NOTES | |
|---|---|
| **Response Strengths** | **Response Weaknesses** |
| The response is good.<br>• Bidder indicates contact with member within 48 hours of assignment.<br>• Bidder indicates tribal CHR.<br>• Bidder indicates assessments such as a drug abuse screening test DAST-10 for member.<br>• Bidder indicates Epic EHR platform.<br>• Bidder indicates experience working respectfully with tribal nations for other states.<br>• Bidder indicates use of peer support specialist.<br>• Bidder indicates IHCP shared coordination process.<br>• Bidder assisted with enrollment in PBPNHC diabetes prevention program.<br>• Bidder provides information regarding NEMT to the member.<br>• Bidder supported member retaining IHC providers.<br>• Bidder provided telemedicine options.<br>• Bidder confirmed the goal of employment for the member.<br>• Bidder reports intention to align member with cultural care.<br>• Bidder provided practice sessions to help individual reconnect with family and supports.<br>• Bidder provided information about 9-8-8 and bidder's 24/7 365 crisis line.<br>• Bidder developed crisis, safety, and relapse prevention plan.<br>• Bidder ensures access to glucometer and supplies. | Weaknesses were identified that can be easily overcome.<br>• Bidder does not indicate MCO care coordinator qualifications.<br>• Bidder does not indicate SMART goals.<br>• Bidder indicates a VAB for $100 for completion of a diabetic retinal eye exam and HbA1c lab work. However, this amount is above the CMS limit.<br>• While bidder provides information regarding NEMT to the member, no discussion is indicated regarding mileage reimbursement.<br>• Bidder response heavily leverages the "CCBHC care coordinator" and indicated limited coordination by the MCO care coordinator.<br>• Bidder's response lacks detail on the therapies that would be utilized.<br>• 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.<br>• Bidder indicates local CCBHC as being Valeo; however, Kanza is the local CCBHC provider for the reservation.<br>• Bidder indicates CCBHC care coordinator appears in person for an assessment. This is unrealistic.<br>• Bidder reported use of ASAM "screener" but response is unclear on member's SUD status and level of care needed. ASAM is an assessment. |

- Bidder provided education on member's alcohol use and relationship to blood sugar levels and Metformin dosage.
- Bidder provides medical nutrition therapy services through ILOS.
- Bidder connects member to VABs such as Healthy Foods program, home delivered meals, transportation, and glasses.
- Bidder connects member to Prairie Band Potawatomi Food Distribution Program and SNAP.
- Bidder connects with Employment Services and Supports Coordinator connecting with Potawatomi Nation Job Training and Placement Program.

- Bidder reported concerns around member's alcohol use but unclear what supports and services or process of connecting member to services.
- 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 indicated referral to Topeka Housing Authority. Kansas Statewide Homeless Coalition would be the HUD provider to address homelessness or at risk of homelessness services and resources on the reservation area where member is currently located.
- Bidder made a 12-step AA referral with no secular alternative and no cultural support group offered.

**General Notes**

**Rating**

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