State of Kansas

KANCARE MEDICAID & CHIP CAPITATED MANAGED CARE

REQUEST FOR PROPOSAL (RFP)

RFP # EVT0009267

Technical Review and Recommendation for Award

May 8, 2024

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I. Background

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

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

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

A. Improve member experience and satisfaction.

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

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

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

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

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

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

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

C. Reduce health care disparities.

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

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

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

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

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

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

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

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

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

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

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

II. KanCare RFP Evaluation of Technical Proposals

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

Phase 1 — Review of Mandatory Requirements

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

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

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

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

Phase 2 — Review of Technical Proposals

Evaluation Committees

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

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

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

Evaluation Criteria

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

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

Rating Scale and Definitions

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

Scoring Methodology

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

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

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

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

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

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

Evaluator Training

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

Evaluation Process for RFP Technical Questions

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

Independent Review

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

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

Consensus Review

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

Use of Subject Matter Experts as Advisors

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

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

III. Technical Proposal Review Results

KanCare RFP Total Technical Scores

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

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

KanCare RFP Technical Scores by Topic Areas

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

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

KanCare RFP Summary of Ratings of Responses

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

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

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

Examples of Technical Proposal Strengths and Weaknesses

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

Sunflower State Health Plan, Inc.

Strengths

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

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

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

Weaknesses

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

UnitedHealthCare of the Midwest, Inc.

Strengths

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

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

Weaknesses

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

Aetna Better Health of Kansas, Inc.

Strengths

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

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

Weaknesses

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

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

Strengths

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

Weaknesses

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

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

CareSource Kansas LLC

Strengths

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

Weaknesses

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

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

Molina Healthcare of Kansas, Inc.

Strengths

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

Weaknesses

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

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

UCare Kansas, Inc.

Strengths

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

Weaknesses

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

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

IV. PNC Request for Release of Cost Proposals

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

V. PNC Award Recommendation

In accordance with RFP Section 6, a negotiated procurement pursuant to K.S.A. 75-37,102, selection and award of the KanCare MCOs must be based upon the best interests of the State of Kansas. In keeping with this guiding principle, the PNC recommends Sunflower State Health Plan, Inc., (Sunflower); UnitedHealthCare of the Midwest, Inc., (United); and Community Care Health Plan of Kansas, Inc. d/b/a Healthy Blue be awarded the KanCare MCO contracts effective January 1, 2025.

Section III of this evaluation (located on page 9) details the ranking and scores of the bidders. Sunflower and United were the top bidders; the cumulative scores of Aetna and Healthy Blue were tied.

Although Aetna's and Healthy Blue's cumulative scores were tied, there were important differences. In the seven (7) major topic areas (also located on page 9), Healthy Blue scored higher than Aetna in five (5) of the seven (7) areas that were being evaluated. These five (5) areas were:

- Experience and Qualifications
- Member Experience
- Utilization Management and Services
- Provider Network
- Case Scenarios

Comparatively, of the same seven (7) major topic areas, Aetna scored higher than Healthy Blue in only two (2). These two (2) areas were:

- Integrated, Whole Person Care
- Quality Assurance

Comparing Aetna and Healthy Blue on consensus rating, Aetna had eight (8) responses rated two (2) (which is 25% of the available points) and one (1) response rated one (1) (which is 0% of the available points). Conversely, Healthy Blue had seven (7) responses rated two (2) and no responses rated one (1). See Attachment 1 for further explanation of the consensus rating.

Provider Network

The Provider Network metric is one of the most complex and recipient-critical criteria on which the RFP applicants were evaluated. It involves tightly written regulations from CMS with which KanCare must comply to guide delivery of services and assurance of provider and consumer satisfaction. Responses from Healthy Blue and Aetna were important in clarifying the final recommendation for the KanCare MCO contract.

Healthy Blue presented the strongest provider network response and ranked first in scoring for the provider network. This score is supported by their RFP response:

- An assurance of member access to non-emergency medical transportation and the impact of NEMT on SODH;
- The strong response on developing, managing and monitoring an adequate qualified network with a tool modeled on CMS audit criteria;
- Ensured timely access to dental care across the state.
- Demonstrated an understanding of the care team model in the Medicaid program and emphasized in the RFP, of the Community Health Worker
    - In follow up question Healthy Blue committed to:
        - the hiring of twenty Community Health Workers (CHW)and or Community Health Representatives (CHR)
        - Maintaining a ratio of (1) CHW/CHR to 10,000 members with an immediate assessment of the need to expand prior to Go-Live and monthly assessment thereafter
        - engaging with currently employed CHWs across the state in FQHCs, CMHCs
        - working with the CHRs in the four recognized tribal nations in KS.

Aetna ranked fourth in its technical scores for provider network:

- Minimally acceptable responses to ensure member access to non-emergency medical transportation
- How to ensure timely access to quality dental care dental care in all areas of the state was not fully described
- Scored minimally acceptable for dental and on NEMT for special needs patients;
- No information on how feedback would be obtained from members on NEMT or on monitoring the effectiveness.
- Has a history of having unresolved issues (corrective actions) for extended periods of time
- Had a lack of detail on backup plans for caregivers for the LTSS population
- Weak response on recruiting Medicaid Providers
- Responses related to provider directory were minimally acceptable; lacked detail in specificity in this area
- Responded the weakest on the use of Community Health Workers
    - In a follow up question Aetna committed to:
        - Expanding their network of (4) CHWs to 10 by January 1, 2025
        - Develop partnerships with tribal nations to utilize CHRs

Attachment 1: KanCare RFP Rating Scale and Definitions

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

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

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

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