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| KANSAS MEDICAID MANAGED CARE REQUEST FOR PROPOSAL FOR KANCARE 2.0  **BID Event Number: EVT****0005464** |

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# 5. RFP Background and Scope of services

## RFP Background

The State of Kansas has determined that continued contracting with multiple managed care organizations (MCOs) will result in the provision of efficient and effective Covered Services to the populations currently covered by Medicaid and the Children’s Health Insurance Program (CHIP) in Kansas, as well as ensure coordination of care and integration of physical and Behavioral Health services with each other and with home- and community-based services (HCBS).

The Kansas Medicaid population is divided into three distinct populations: (1) parents, pregnant women and children, (2) various disability groups (e.g., individuals with intellectual/developmental [IDD] or physical disabilities [PD], or both, and persons with Severe and Persistent Mental Illness), and (3) the aged (65 and older). All populations are currently covered by the State Medicaid Plan, KanCare, and will continue to be covered by the successful bidders related to this request for proposal (RFP). The total KanCare covered population is approximately 403,000. Roughly 323,000 are parents, pregnant women and children. Another 44,000 individuals are disabled and about 67,000 are aged.

Presently, Kansas Medicaid services are managed across two State agencies. The Kansas Department of Health and Environment (KDHE) is the single State Medicaid agency, and its Division of Health Care Finance (DHCF) is responsible for the Medicaid State Plan, interactions with the Centers for Medicare & Medicaid Services (CMS), drawing down Federal Financial Participation (FFP) funds, and managing physical health care for all Medicaid Beneficiaries and Behavioral Health for children enrolled in CHIP. KDHE-DHCF also formulates eligibility policy and manages the Eligibility Clearinghouse, where all KanCare eligibility determinations are made.

The Kansas Department for Aging and Disability Services (KDADS) manages Behavioral Health care for the non-CHIP populations, the seven HCBS Waivers, nursing facilities (NFs), intermediate care facilities for individuals with intellectual/developmental disabilities (ICF/IDD), and the Program for All-Inclusive Care for the Elderly (PACE).

The following 1915(c) HCBS Waiver populations are currently served within the managed care program known as KanCare (refer to Attachment B for a list of current 1915(c) Waivers):

1. Children with autism
2. Children and adults with intellectual and developmental disabilities (IDD)
3. People ages 16–64 with PD
4. Medically fragile children ages 0–22 dependent on intensive medical technology (TA)
5. People ages 16–64 with traumatic brain injuries (TBI)
6. People ages 65 and older who are functionally eligible for nursing facilities (NF)
7. Children with a serious emotional disturbance (SED)

These HCBS populations receive all of their physical and Behavioral Health services, as well as their long-term services and supports (LTSS), through managed care.

One of the primary aims of this RFP is to improve integration and coordination of care for this group which contains individuals who have multiple Chronic Conditions. The State expects the CONTRACTOR(S) to utilize the existing Service Coordination and Case Management structures at the local level to achieve desired Outcomes and to contract with local providers for Outcomes‑based Service Coordination services whenever feasible. While managing several populations and programs allows for administrative efficiencies, Kansas CONTRACTOR(S) are required to report separately on expenditures and utilization for Behavioral Health, physical health, LTSS, and HCBS.

Additional aims for providing all services in a comprehensive managed care CONTRACT are to:

1. Measurably improve health care Outcomes for Members in a number of areas, including, but not limited to:
2. Improve coordination and integration of physical health, Behavioral Health, and LTSS.
3. Support Members successfully in their communities, as well as connect Members to housing, food, employment, education, and to other Social Determinants of Health and Independence as needed.
4. Promote wellness and healthy lifestyles
5. Lower the overall cost of health care

### General KanCare 2.0 Requirements

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for Social Determinants of Health and Independence, in addition to traditional Medicaid and CHIP benefits. Kansas will test the below hypotheses in KanCare 2.0 through this RFP and through the Section 1115 Medicaid Demonstration Waiver:

1. Expanding Service Coordination to include assisting Members with accessing affordable housing, food security, employment, and other Social Determinants of Health and Independence will increase independence and stability and improve health Outcomes.
2. Increasing employment and independent living supports for Members with Behavioral Health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health Outcomes.
3. Providing Service Coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health Outcomes for these youth.

Almost all Medicaid Beneficiaries and 100% of CHIP Beneficiaries will enroll in an MCO of their choosing. Certain Medicaid Beneficiaries including dual eligibles (Medicare and Medicaid), foster care children, and children with disabilities may be voluntarily enrolled, and may not be enrolled on a mandatory basis without a Waiver from CMS. Kansas' managed care program will operate under the Waiver authority specified in sections1115 and 1915(c) of the Social Security Act (SSA).

CONTRACTOR(S) is required to bid for all populations, services, and regions of the State. To solicit capitation bids from interested CONTRACTOR(S), the State will utilize a competitive bidding process.

### Requirements for CONTRACTOR(S) to Demonstrate

The CONTRACTOR(S) must submit proposals that adequately demonstrate how it will perform each of the functions required as detailed in this RFP in Sections 5.2 through Section 8 in sufficient detail to allow the State to assess the CONTRACTOR(S) ability to meet the requirements.

### Geographic Service Area

CONTRACTOR(S) must submit proposals that provide for statewide coverage; there will be no regional coverage. The number of CONTRACTOR(S) with which the State contracts will be sufficient to ensure statewide coverage is feasible based on adequate enrollment in each CONTRACTOR(S). This will also lessen the number of disenrollments when Members move from one location in the State to another.

Any proposal that does not offer statewide coverage will not be considered in the bid evaluation process.

### Functions and Duties of the CONTRACTOR(S)

1. The CONTRACTOR(S) shall:
2. Retain at all times during the period of this CONTRACT, a valid Certificate of Authority issued by the Kansas Department of Insurance.
3. Certify to the State, in accordance with section 1932(d)(1) of the SSA 42 CFR § 438.610, that the CONTRACTOR(S) and any Subcontractors do not have any prohibited affiliations.
4. CONTRACTOR(S) is responsible to ensure that all required databases, as specified in 42 CFR § 455.436 and as directed by the State, are checked.
5. In accordance with CMS Release No. 35, Medicaid Clinical Laboratory Improvement Amendments (CLIA) implementation, the CONTRACTOR(S) shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Titles XIX and XXI of the SSA. The CONTRACTOR(S) shall provide a listing to the State of all laboratories and/or entities providing laboratory services used by the CONTRACTOR(S) and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. The CONTRACTOR(S) shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.
6. Comply with all other applicable Federal and State statutes and regulations governing CONTRACTOR(S), including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990 as amended, section 1557 of the Patient Protection and Affordable Care Act (PPACA), and Titles XIX and XXI of the SSA.
7. The CONTRACTOR(S) must comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members.

#### Business Continuity/Disaster Recovery Plan

Within 90 days of award, the CONTRACTOR(S) shall develop and submit for State approval, a Business Continuity/Disaster Recovery Plan. The Plan shall include the Subcontractor(s)’ plans and the following components:

1. CONTRACTOR(S) must provide a Business Continuity/Disaster Recovery Plan for the technology and infrastructure components, as well as for the business area operations continuity and contingency plan. CONTRACTOR(S), together with the State, must affirm the Business Continuity/Disaster Recovery Plan, the essential roles, responsibilities, and coordination efforts for those portions of the technical infrastructure and operations as deemed appropriate.
2. CONTRACTOR(S) must address a wide range of infrastructure and services recovery responsibility associated with, and/or arising from partial loss of a function or of data for a brief amount of time to a worst-case scenario in which a man-made or natural disaster, data center equipment or infrastructure failure, or total system failure may result.
3. It is the policy of KDHE-DHCF that a Business Continuity/Disaster Recovery Plan is in place and maintained at all times. The plans contain procedures for data backup, disaster recovery including restoration of data, and emergency mode operations. The plans must include a procedure to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency. Also, access control will include procedures for emergency access to electronic information.
4. CONTRACTOR(S)’ systems must be protected against hardware and software failures, human error, natural disasters, and other emergencies which could interrupt services. The plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure.
5. CONTRACTOR(S) must develop a Business Continuity Plan which includes the following:
6. Identification of the core business processes involved in the CONTRACTOR(S)’ system
7. Plan for each core business process:

Identification of potential system failures for the process

Risk analysis

Impact analysis

Definition of minimum acceptable levels of outputs

1. Documentation of contingency plans
2. Definition of triggers for activating contingency plans
3. Discussion of establishment of a business resumption team
4. Maintenance of updated Disaster Recovery Plans and procedures
5. Plan for replacement of personnel to include the following as a minimum:

Replacement in the event of loss of personnel before or after signing this CONTRACT.

Replacement in the event of inability by personnel to meet performance standards.

Allocation of additional resources in the event of the CONTRACTOR(S)’ inability to meet performance standards:

Replacement/addition of personnel with specific qualifications

Timeframes necessary for replacement

Capability of providing replacements/additions with comparable experience

Methods for ensuring timely productivity from replacements/additions

1. CONTRACTOR(S) must prepare a Disaster Recovery Plan which addresses the following:
2. Retention and storage of backup files and software
3. Hardware backup for critical system components
4. Facility backup
5. Backup for telecommunications links and networks
6. Staffing plan
7. Backup procedures and support to accommodate the loss of online communications
8. A detailed file backup plan and procedures, including the offsite storage of crucial transaction and master files; the plan and procedures must include a detailed frequency schedule for backing up critical files and (if appropriate to the backup media) their rotation to an offsite storage facility. The offsite storage facility must provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations.
9. The maintenance of current system documentation and source program libraries at an offsite location.
10. The Disaster Recovery Plan and results of periodic disaster readiness simulations must be available for review by State or Federal officials on request. This report and test results must be filed annually with the KDHE-DHCF Senior Contract Manager and any other agency authorized by KDHE-DHCF or the Federal government. This report and test results must be approved by the KDHE-DHCF Senior Contract Manager.

#### Security Management Plan

Within 90 days of award, the CONTRACTOR(S) shall develop and submit for State approval, a Security Management Plan. The Plan shall include the Subcontractor(s)’ plans and the following components:

1. The Security Management Plan shall document the CONTRACTOR(S)’ plan to prevent unauthorized disclosure of data and information. KDHE-DHCF must initially approve the Security Management Plan, and will conduct audits/evaluations of the security plan established by the CONTRACTOR(S) at least annually.
2. The security plan must include the following elements for all sites where system development will occur, will host any KDHE-DHCF data, or will be interacting with the public. The CONTRACTOR(S) is required to keep the plan up to date.
3. The Security Plan shall include, but not limited to, the following:
4. Comprehensive Risk Assessment evaluating the security risks, vulnerabilities and threats to the system. CONTRACTOR(S) must review and update this Risk Assessment annually in coordination with KDHE-DHCF and the State of Kansas Chief Information Security Officer.
5. Privacy Impact Analysis that identifies the data elements of the system that expose Beneficiaries to potential privacy threats and the system controls in place to mitigate private data disclosure risks.
6. Security event notification process, event evaluation and escalation procedures, and security event response procedures.
7. Complete network diagram showing servers, printers, workstations, firewalls, intrusion prevention systems, network security device internet connections, and any other network connected device.
8. Complete list of the firewall rules for any applicable firewalls.
9. Detailed plan for system log collection and monitoring.
10. Antivirus deployment/maintenance plan.
11. Software maintenance plan, including operation systems and third-party software updates.
12. An agreement that background checks will be completed and passed by all employees prior to allowing access to KDHE-DHCF data.
13. Background checks every five (5) years after employment.
14. Procedures to limit access to information to those individuals who need such information for the performance of their job functions and ensuring that those individuals have access to only the information that is the minimum necessary for the performance of their job functions.
15. Description of how physical safety of data under its control will be protected through the use of appropriate devices and methods, including, but not limited to, alarm systems, locked files, guards, or other devices reasonably expected to prevent loss or unauthorized access to data.
16. Description of the steps taken to prevent unauthorized use of passwords, access logs, badges, or other methods designed to prevent loss of, or unauthorized access to, electronically or mechanically held data. Methods used shall include, but not be limited to, restricting system and/or terminal access at various levels, assigning personal IDs and passwords that are tied to preassigned access rights to enter the system, restricting access to input and output documents, including a view-only access and other restrictions designed to protect data.
17. An agreement to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules as a business associate of KDHE and KDADS.
18. Requiring that each employee, including the employees of Subcontractors or any other person to whom the CONTRACTOR(S) grants access to information under this CONTRACT, has signed a statement indicating he or she has been informed of, understands, and will abide by State and Federal laws, rules, statutes, guidelines, and regulations concerning confidentiality, privacy, and security. A system of sanctions for any employee, Subcontractor, officer, or director who violates the privacy and security policies shall be enforced.
19. CONTRACTOR(S) must submit a copy of the approved User Security Agreement (initial and annually) required of all of their employees or Subcontractors who will come into contact with any secure information or data.
20. Procedures to ensure that corrective action occurs and mechanisms are established to avoid the reoccurrence of any breach.
21. Procedures established to recover data should it be released without authorization.
22. A designated individual who is responsible for the implementation and monitoring of compliance with privacy and security policies and procedures.
23. Procedures and processes for securing data access across organizational boundaries, through the internet and other leased lines, or shared with CONTRACTOR(S) and Subcontractor facilities, and all onsite and offsite data storage facilities.
24. CONTRACTOR(S) will engage a third party, of the State’s choosing, to conduct thorough system penetration testing prior to contract implantation, for their systems and Subcontractor(s)’ systems. CONTRACTOR(S) will develop a Corrective Action Plan for all vulnerabilities discovered during the penetration testing. CONTRACTOR(S) will conduct additional penetration testing annually and report the results to the State.
25. An Infrastructure Security Plan.

### Cooperation With Other Agencies

Cooperation with other State agencies and programs, as identified in this section, is expected, and CONTRACTOR(S) must track and regularly provide evidence of the cooperation, work, and collaboration accomplished.

1. CONTRACTOR(S) shall make a reasonable effort to subcontract with any local health care Provider receiving funds from Titles V and X of the SSA. Close cooperation with these entities is expected.
2. CONTRACTOR(S) shall coordinate all cases of Sexually Transmitted Diseases (STDs) and tuberculosis (TB) with the local health departments to ensure prevention and to limit the spread of disease. The CONTRACTOR(S) shall cooperate with the treatment plan developed by the State and local health departments. The State requires the CONTRACTOR(S) to provide language, in their subcontracts with any local health departments, regarding the coordination of care and reporting on STDs and TB to the State health department.
3. CONTRACTOR(S) shall coordinate with the Special Supplemental Food Program for Women, Infants and Children (WIC). The State shall assure that coordination exists between the WIC and CONTRACTOR(S). This coordination should include the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by Providers working within managed care plans to the WIC Program:
4. To be eligible for WIC benefits, a competent professional authority must diagnose a pregnant woman, a breast-feeding woman, a non-breast feeding postpartum woman, an infant or a child under age five (5) as being at nutritional risk. Suggested medical information for a WIC referral includes: nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, premature birth, infants of alcoholic mothers, developmentally disabled infants, drug addicted or HIV positive mothers, AIDS, allergy or intolerance that affects nutritional status, and anemia.
5. The WIC Program in the State of Kansas is coordinated through the State and local health departments. CONTRACTOR(S) is expected to subcontract or coordinate with the local health departments in their service areas.
6. CONTRACTOR(S) shall also coordinate with other Title V programs such as programs funded under the Individuals with Disabilities Education Act, the Healthy Start Home Visiting Program, the Maternal and Infant and Family Planning Clinics as well as any other programs operated by the State and local health departments.
7. CONTRACTOR(S) shall also cooperate with the justice systems in Kansas, to include but not limited to, Kansas Department of Corrections and Juvenile Justice.
8. Local Education Agencies: CONTRACTOR(S) is required to cooperate with these Local Education Agencies for the provision of Covered Services. The State will be monitoring this cooperation in order to assess possible future CONTRACT requirements.
9. CONTRACTOR(S) shall coordinate with any Indian Health Service Clinics or tribally operated facilities in their service area. Documentation of such coordination is required.

### Reproduction of Materials

The CONTRACTOR(S) shall reproduce and distribute information and documents provided by the State necessary for CONTRACTOR(S)’ Participating Providers to fully implement the requirements of this Contract at CONTRACTOR(S)’ expense. Examples include, but are not limited to, forms, policy changes, and Member rosters. Information and documents will be disseminated in accordance with a reasonable time frame as determined by the State. CONTRACTOR(S) may use mail, electronic websites or bulletin boards, secure email, facsimile (fax), or any other communication method approved by the State.

## Enrollment, Disenrollment, and Marketing

### Enrollment

1. Enrollment includes the following:
2. Member enrollment/assignment: Enrollment for the new CONTRACT period will begin prior to November 1, 2018 and continue on an ongoing basis.

Medicaid Members aged less than 21 and CHIP beneficiaries aged less than 19 will have a continuous twelve (12)-month period of eligibility.

Assignment for Members is effective the first (1st) day of the eligibility start month. Assignment for CHIP Members shall begin the day eligibility is received by the Medicaid Management Information System (MMIS) and is forwarded to the CONTRACTOR(S).

Beneficiaries eligible to enroll with a CONTRACTOR(S) may be eligible beginning the first (1st) day of the application month with the exception of newborns who are eligible beginning with their date of birth.

Newborns of eligible mothers who were enrolled at the time of the child’s birth shall be covered under the mother’s CONTRACTOR. The CONTRACTOR(S) shall receive a capitation payment for the month of birth and for all subsequent months the child remains enrolled with the CONTRACTOR if the CONTRACTOR provided the newborn information to the State within sixty (60) calendar days of the date of birth. If there is an administrative lag that is not the fault of the Member in enrolling the newborn and costs are incurred during that period, the Member shall be held harmless for those costs.

Neither Medicaid nor CHIP Members are subject to waiting periods or pre‑existing condition clauses excluding coverage for conditions as of the effective date of their coverage. Enrollment in the Medicaid and CHIP KanCare programs is the responsibility of the State and its Fiscal Agent.

Managed physical, behavioral, LTSS, as well as dental services for those currently eligible for them, must be available to Members at the time of enrollment.

1. Beneficiaries eligible for enrollment with CONTRACTOR(S) are those encompassed by the categories listed in the Kansas 1115 Waiver Special Terms and Conditions found at the following URL site: <http://www.kancare.ks.gov/about-kancare/history-of-kancare>

The State shall have the exclusive right to determine an individual’s eligibility for Medicaid. The State, through its Eligibility Broker, shall have the exclusive right to determine an individual’s eligibility for CHIP.

Such determinations are not subject to review or appeal by the CONTRACTOR(S).

Nothing in this section prevents the CONTRACTOR(S) from providing the State with information the CONTRACTOR(S) believes indicates that the Member’s eligibility has changed.

1. For the first CONTRACT year, Members who were enrolled with an MCO that was previously contracted with the State, will be auto-assigned to that CONTRACTOR. Members that were previously enrolled with an MCO that is not continuing to CONTRACT with the State and newly eligible Beneficiaries will be randomly assigned to a new MCO using an auto-assignment algorithm that ensures family Members stay with the same MCO, that existing Provider-Member relationships are maintained to the extent possible, and that ultimately targets an equitable distribution of Members across the CONTRACTORS based on both numbers and acuity of Members and newly eligible Beneficiaries. The State, through its Fiscal Agent, will notify Members that they have ninety (90) calendar days from January 1, 2019 to choose another CONTRACTOR. Along with this notification, the State, through its Fiscal Agent, will send an enrollment packet on all available CONTRACTOR(S) to allow Members the opportunity to make an informed choice of CONTRACTOR(S). The enrollment packet will explain services, network options, and information specified in Section 5.2.1.P.5.b, including information explaining the implications of not making an active choice of a CONTRACTOR, enrollment information including the ninety (90) day without-cause disenrollment period, and other disenrollment rights in accordance with 42 CFR § 438.56.

The State may, at its discretion, alter the algorithm per 42 CFR § 438.54(d)(8)(ii) by considering additional criteria to conduct the default enrollment process, including the enrollment preferences of family members, previous MCO assignment of the Member, quality assurance and improvement performance, procurement evaluation elements, accessibility of Provider offices for people with disabilities (when appropriate), and other reasonable criteria related to a Member’s experience with the Medicaid program.

1. Members with enrollment questions may contact the Fiscal Agent. When the Member chooses, or is assigned a CONTRACTOR, the Fiscal Agent will send the Member a letter informing them of the assigned CONTRACTOR.
2. CONTRACTOR(S) will send the Member a Member Handbook including the information in Sections 5.10.6 and 5.10.7 and allow the Member ten (10) business days to choose a Primary Care Physician (PCP). If the Member does not choose a PCP within ten (10) business days, the CONTRACTOR(S) shall auto-assign the Member to a PCP.
3. Members will be informed that they may request and be assigned a new PCP at any time.
4. The Member Handbook will include all elements found in Section 5.10.5.
5. Additionally, the CONTRACTOR(S) shall send the Member an identification card containing at a minimum all elements found in Section 5.10.9.
6. CONTRACTOR(S) will maintain a permanent Member service hotline, with specially trained operators to handle calls from new Members and from Members needing assistance in obtaining services as identified further in Section 5.10.10.
7. CONTRACTOR(S) shall also be responsible to provide retroactive Medicaid coverage to Members determined eligible by the State.
8. Retroactive Medicaid coverage is defined as a period of time generally up to three (3) months prior to the application month. (In general, there is no retroactive coverage for CHIP Members. However, it is allowed in certain limited instances, such as for newly eligible CHIP babies, specific instances when reinstating CHIP coverage due to overdue premiums, review reconsideration periods, and the retroactive Title 21 process.)
9. When a retroactive assignment is made to the CONTRACTOR(S), the CONTRACTOR(S) is responsible for paying the historical claims even if the claims are past the CONTRACTOR(S)’ timely filing policies. The CONTRACTOR(S) must submit for State approval policies for timely filing and authorization exceptions which must include provisions for retroactive eligibility assignments. These policies must be in effect at the beginning of the CONTRACT.
10. The Assignment Adjustment Process is used when a change to the existing CONTRACTOR(S)’ assignment occurs. The adjustment is approved by the State. A CONTRACTOR(S) cannot change MCO assignments without State approval and will be triggered by MMIS updates.
11. When an assignment is removed from the CONTRACTOR(S), a recoupment of the capitation payment will occur for the appropriate months.
12. When an assignment is added to the CONTRACTOR(S), a capitation payment will be made for the appropriate months.
13. CONTRACTOR(S) Responsibilities:
14. CONTRACTOR(S) shall accept, on a monthly basis, any eligible Member who selects or is assigned to the CONTRACTOR(S) in the order in which they apply or are assigned without restriction, (unless authorized by the Regional Administrator), up to the limits set under the CONTRACT regardless of the Member’s race, color, national origin, age, sex, sexual orientation, gender identity, disability, ethnicity, language needs, or health status up to the limits set under the CONTRACT.
15. These Members must also appear on the CONTRACTOR(S)’ enrollment information. Enrollment in the CONTRACTOR(S) will occur starting with the first (1st) month of eligibility for Medicaid Members and the day eligibility is forwarded to the CONTRACTOR(S) for CHIP Members. The CONTRACTOR(S) is responsible for obtaining any necessary signatures of medical releases.
16. Coverage of services, including inpatient hospital care, will be the responsibility of the CONTRACTOR(S) as of the beginning of the month enrollment becomes effective. All other (ancillary) charges, not reimbursed by the inpatient hospital payments, are the responsibility of the CONTRACTOR(S). Non-inpatient (ancillary) charges are the responsibility of the CONTRACTOR(S) if the Admission date occurs before assignment. If an Admission date occurs during the assignment to the CONTRACTOR(S), that CONTRACTOR(S) is responsible for the cost of the entire Admission regardless of assignment or eligibility.
17. CONTRACTOR(S) must have written policies and procedures for providing all medically necessary services required under the benefit package to newborn children of program Members effective at the time of birth.
18. CONTRACTOR(S) must agree to make available the full scope of benefits to which a Member is entitled immediately upon the effective date of enrollment.
19. CONTRACTOR(S) must have written policies and procedures for orienting new Members and potential Members to their benefits, rights, and features of their health plan per 42 CFR § 438.10(e). The CONTRACTOR(S) may propose alternative methods for orienting new Members and potential Members, but must be prepared to demonstrate their effectiveness. Also, refer to Section 5.10.7 for requirements regarding the Member Handbook.
20. CONTRACTOR(S) must have written policies and procedures for assigning each of its Members to a PCP. The process must include at least the following features:
21. CONTRACTOR(S) must contact the Member within ten (10) business days of his or her enrollment and provide information on the options for selecting a PCP.
22. If a Member does not select a PCP within ten (10) business days of enrollment, the CONTRACTOR(S) must make an automatic assignment, taking into consideration such factors, if known, as current Provider relationships, language need, cultural competency, and area of residence. The CONTRACTOR(S) may choose to assign new Members to a PCP immediately, notify the Member of that assignment in writing, and allow the Member to change this assignment at any time if it is not acceptable. The CONTRACTOR(S) must notify the Member in writing of his or her PCP’s name, specialty, hospital affiliation, and office telephone number and also notify that the Member may change at any time, for any reason.
23. If a PCP is terminated from a CONTRACTOR(S), the CONTRACTOR(S) shall have written policies and procedures for Members to select or be assigned to a new PCP within fifteen (15) days of the termination effective date.
24. Following the original assignment to a CONTRACTOR, the Member will have a 90-day period to change to a different CONTRACTOR, if desired.
25. Member choice of a CONTRACTOR(S) shall be voluntary, and neither the State nor its agents shall do anything to influence the Member’s exercise of free choice.
26. Members shall be provided assurances that a decision not to enroll in a CONTRACTOR(S) shall not affect their eligibility for benefits.
27. An application for enrollment in the program and selection of a CONTRACTOR, which includes a list of CONTRACTOR(S), will be provided to the Members. Fiscal Agent managed care enrollment staff will be available, by calling a toll-free number or in person to assist Members that request a change in CONTRACTOR.
28. A brochure explaining the managed care program and CONTRACTOR(S)’ services (including Value-Added Benefits) will be provided to Members per Section 5.10.5. Members will be advised as to which CONTRACTOR(S) offer special services that the Member may need. In addition, these materials will be offered in alternate formats to address physical and language barriers in accordance with 42 CFR § 438.10.
29. State Responsibilities:
30. The State will conduct education and enrollment activities for program Members.
31. The State will make available to the CONTRACTOR(S) on a monthly basis, an electronic roster of Members enrolled in the CONTRACTOR(S) for the entire benefit month. The roster will include information consistent with the HIPAA‑compliant 834 transaction.
32. The State will make available to the CONTRACTOR(S) on a daily basis, an electronic roster (HIPAA 834) of Members enrolled in the CONTRACTOR. This roster will contain Medicaid newborn children and CHIP daily assignments.
33. The State will maintain and notify Members of the Annual Open Enrollment period, as specific to each Member, for CONTRACTOR(S) selection for the subsequent CONTRACT year.
34. The State’s responsibilities at the time of the eligibility determination will include the following:

Educating Beneficiaries about the basic features of managed care consistent with the requirements in 42 CFR § 438.10(e)(2).

Informing Beneficiaries of available CONTRACTOR(S) and outlining criteria that might be important when making a choice (e.g., presence or absence of the Beneficiary’s existing health care Provider in a CONTRACTOR(S)’ network), and that they will remain enrolled in that CONTRACTOR(S) for the following year, unless a specific “for cause” exception is met consistent with 42 CFR § 438.56 and the terms of the KanCare program.

Members who lose eligibility due to failure to provide eligibility information to the State on a timely basis, but those whose eligibility is subsequently re-established prior to the end of the month will be reported to the CONTRACTOR(S) on a second Member roster sent to the CONTRACTOR(S) on or around the fifth (5th) of each month. Capitation for those Members reported on this second roster will be made with the regular capitation payment for the following month.

No CONTRACTOR(S) will be permitted enrollment numbers that constitute more than 50% of the total eligible Medicaid and CHIP population. Should any CONTRACTOR(S) in the first (implementation) year fall below enrollment of 20% of the total Medicaid and CHIP population, the assignment algorithm will be reassessed.

### Disenrollment

1. Disenrollment provisions apply to all managed care arrangements per 42 CFR § 438.56.
2. Members may disenroll as outlined in 42 CFR § 438.56 with cause at any time, without cause during the 90-day choice period following the initial enrollment, and during the Annual Open Enrollment period thereafter.
3. Members who wish to disenroll must submit an oral or written request to the State or its Fiscal Agent. These disenrollments will be effective on the first (1st) day of the second (2nd) month following the month in which the Member or CONTRACTOR(S) filed the request for disenrollment, whenever possible.
4. The effective date of an approved disenrollment must be no later than the first (1st) day of the second (2nd) month following the month in which the Member or CONTRACTOR(S) files the request for disenrollment.
5. If the State or its Fiscal Agent fails to make the determination within the timeframes specified herein, the disenrollment is considered approved.
6. CONTRACTOR(S) Responsibilities:
7. The CONTRACTOR(S)’ responsibility for Member-initiated disenrollments shall include referring the Member to the Fiscal Agent’s Managed Care Enrollment Center to process the disenrollment.
8. The CONTRACTOR(S) is also required to track the reason for the disenrollments for the CONTRACTOR(S)’ Quality Assessment and Performance Improvement (QAPI) process.
9. The CONTRACTOR(S) shall inform Members of their disenrollment rights in accordance with 42 CFR § 438.56, including the 90-day without cause disenrollment period.
10. The CONTRACTOR(S) shall have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when a Member is transferred to or from another CONTRACTOR. It may be necessary to transfer a Member between CONTRACTOR(S). As an example, the transfer may be necessary if the change is ordered as part of a grievance resolution.
11. When a Member changes CONTRACTOR(S) while hospitalized, the relinquishing CONTRACTOR(S) shall notify the hospital of the change prior to the transition.

The relinquishing CONTRACTOR(S) shall be responsible for payment of inpatient charges for the entire hospitalization through discharge.

All other non-inpatient (ancillary) charges are the responsibility of the new CONTRACTOR(S) at the beginning of the first (1st) month of enrollment.

1. The CONTRACTOR(S) may send a request to the State for disenrollment of a Member, but may not request disenrollment because of a change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the CONTRACTOR(S)’ ability to furnish services to either this particular Member or other Members).
2. The CONTRACTOR(S) may not request disenrollment for reasons other than those permitted under the CONTRACT. The State will review and must approve any CONTRACTOR(S) requests for disenrollment.
3. The CONTRACTOR(S) must also meet applicable Care Transition and Diversion Activity Requirements identified in Section 5.4.12.

### Marketing

1. Marketing means any communication, from a CONTRACTOR(S) to a Medicaid/CHIP Beneficiary who is not enrolled in that CONTRACTOR(S)’ Medicaid product, that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular CONTRACTOR(S)’ Medicaid/CHIP product, or either to not enroll in, or to disenroll from, another CONTRACTOR(S)’ Medicaid/CHIP product.
2. The CONTRACTOR(S) shall not influence Beneficiary enrollment in the CONTRACTOR(S)’ plan through the offer of any compensation, reward, or benefit to the Member except for additional health-related services or informational or educational services that have been approved by the State.
3. The CONTRACTOR(S) must comply with the following marketing restrictions as specified in 42 CFR § 438.104:
4. The CONTRACTOR(S) shall not conduct directly or indirectly, door-to-door, telephonic, email, texting, or other forms of “cold-call” marketing. Cold call marketing means any unsolicited personal contact by the CONTRACTOR(S) with a potential Member for the purpose of marketing as defined in paragraph A.
5. The CONTRACTOR(S) may not make any communication to a person, who is not enrolled with the CONTRACTOR, which can reasonably be interpreted as intended to influence the Beneficiary to enroll in the CONTRACTOR(S), or to influence any enrollment or disenrollment decisions the Beneficiary might make.
6. The following requirements apply to marketing materials, which are defined as any materials that are produced in any medium by or on behalf of the CONTRACTOR(S) that can reasonably be interpreted as intended to market to potential Members.
7. Marketing materials cannot contain any assertion or statement (whether written or oral) that:

The Beneficiary must enroll in the CONTRACTOR(S)’ plan in order to obtain benefits or in order not to lose benefits.

That the CONTRACTOR(S) is endorsed by CMS, the Federal or State government, or similar entity.

1. The CONTRACTOR(S) shall not distribute any marketing materials without first obtaining the State’s approval. The material must be co-branded with the KanCare logo unless otherwise approved.
2. CONTRACTOR(S) shall distribute marketing materials to its entire Membership and service area, unless otherwise approved by the State.
3. CONTRACTOR(S) shall not offer the sale of any other type of insurance product as an enticement to enrollment.
4. CONTRACTOR(S) marketing, including plans and materials, must be accurate, shall not contain false or misleading information, and does not mislead, confuse, or defraud the recipients or the State.
5. CONTRACTOR(S) shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. (Private insurance does not include a qualified health plan, as defined in 45 CFR § 155.20).

## Covered Services

### Covered and Non-Covered Services

1. The CONTRACTOR(S) shall assume responsibility for all physical health, Behavioral Health, and LTSS (including HCBS and NFs) to the populations listed in the KanCare Section 1115 Waiver found at the following URL site: <http://www.kancare.ks.gov/about-kancare/history-of-kancare>.
2. The CONTRACTOR(S) shall ensure the provision of medically necessary services, including prescription drugs, as specified in, but not limited to, those in Attachment C. The CONTRACTOR(S) shall ensure that Covered Services are available 24 hours a day, seven days a week, as medically necessary.
3. The CONTRACTOR(S) shall ensure continuity, coordination, and integration of physical health, Behavioral Health, and LTSS and ensure collaboration among Providers, including community Providers. All Provider qualifications will follow the Provider Manuals and Practice Acts detailed in Section 5.5.1 of this CONTRACT.
4. The CONTRACTOR(S) shall furnish Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same benefit/service as specified in the Provider Manuals and Attachment C.
5. Per 42 CFR § 438.210, the CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as medical necessity or for utilization management (UM) as long as alternative services are offered and available and can be expected to meet the treatment needs of the Member and not in violation of the Mental Health Parity and Addictions Equity Act (MHPAEA).
6. The CONTRACTOR(S) shall cover services provided outside of the State of Kansas pursuant to 42 CFR § Part 431, subpart B. This includes services that, as determined on the basis of medical necessity, are more readily available in other states and services needed due to an emergency medical condition. The CONTRACTOR(S) shall not routinely cover any services provided outside of the continental United States.

### Value-Added Benefits

1. The CONTRACTOR(S) may offer Value-Added Benefits to Members. Value-Added Benefits may be actual health care services, benefits, or positive incentives that the State determines will promote healthy lifestyles and improved health Outcomes among Members. Value-Added Benefits must be services not already covered under the Kansas Medicaid State Plan. Best practice approaches to delivering Covered Services are not considered Value-Added Benefits. Value-Added Benefits may include anything permissible under applicable Federal Medicaid and CHIP regulations, including incentives consistent with the HHS OIG Special Advisory Bulletin located at <https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf>. State approved Value-Added Benefits shall be provided for the duration of the CONTRACT.
2. If the CONTRACTOR(S) chooses to offer Value-Added Benefits, they must be offered statewide and be available to all Members, as appropriate.
3. Value-Added Benefits must meet the CONTRACTOR(S)’ Members’ needs and support the goals of KanCare. In developing Value-Added Benefits, the CONTRACTOR(S) is encouraged to consider:
4. Adult dental exams and cleanings
5. Smoking cessation counseling
6. Services for pregnant women
7. Services for the elderly
8. Services that support a bridge to independence and private health coverage (e.g., job counseling, appropriate clothing for job interviews, assistance with completing documentation for official forms, health literacy activities)
9. Additional transportation services (e.g., transportation to a job interview)
10. Value-Added Benefits do not need to be consistent across CONTRACTOR(S).
11. Value-Added Benefits shall be prior approved in writing by the State. Upon approval, the Value-Added Benefits shall become part of the CONTRACTOR(S) scope of services for the duration of the CONTRACT Term. The State retains complete discretion regarding maintaining a Value-Added Benefit and may without cause disallow any request for modification or discontinuation of a Value-Added Benefit(s) prior to the end of the CONTRACT Term. In seeking approval of the Value-Added Benefit, the CONTRACTOR(S) shall submit the following information (i) with its response to the RFP, and (ii) at least ninety (90) calendar days prior to the start of each of calendar year.
12. Identify the category or group of Members eligible to receive the proposed Value‑Added Benefit if it is a type of service that is not appropriate for all Members.
13. Describe any limits and/or restrictions for the Value-Added Benefit, including, but not limited to, Prior Authorization (PA) requirements.
14. Describe how the CONTRACTOR(S) will identify the Value-Added Benefit in Encounter Data.
15. Propose how and when the CONTRACTOR(S) will notify Providers, Beneficiaries, and Members about the availability of such Value-Added Benefits while still meeting the requirements of 42 CFR § 438.104.
16. Describe the CONTRACTOR(S)’ methods to provide continuing education and awareness to both Members and Providers throughout the year on the availability of the Value-Added Benefits.
17. Describe how the CONTRACTOR(S)’ customer service staff will be trained on the Value-Added Benefits.
18. Value-Added Benefits are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate-setting process and must be provided at no additional cost to the State. The CONTRACTOR(S) shall not pass on the cost of the Value-Added Benefits to Providers or Members.
19. The CONTRACTOR(S) must specify the conditions and parameters regarding the delivery of the Value-Added Benefits in the CONTRACTOR(S)’ marketing materials and Member Handbook, and must clearly describe any limitations or conditions specific to the Value-Added Benefits, including:
20. Note any limits or restrictions that apply to the Value-Added Benefit
21. Identify the Providers responsible for providing the Value-Added Benefit
22. Describe how a Member may obtain or access the Value-Added Benefit
23. Indicate that there are no grievances and appeal rights for Value-Added Benefits
24. Include a statement that the CONTRACTOR(S) will provide such Value-Added Benefit throughout the CONTRACT term
25. The CONTRACTOR(S) shall provide a Value-Added Benefit report in a format and frequency determined by the State.

### In Lieu of Services

1. The CONTRACTOR(S) may provide in lieu of services, which are medically appropriate and cost effective services or settings to those covered under the State Plan, if prior approved by the State.
2. To receive approval of an in lieu of service, the CONTRACTOR(S) shall perform a cost-benefit analysis for any in lieu of service or setting it proposes to provide, including how the proposed service would be a medically appropriate and cost‑effective substitute for a Covered Service. The CONTRACTOR(S) shall submit the proposed analysis to the State in the format prescribed by the State.
3. The CONTRACTOR(S) may not require a Member to receive an in lieu of service instead of a Covered Service.
4. Approved in lieu of services are offered to Members at the option of the CONTRACTOR(S).
5. If the State approves the in lieu of service, the State will take into account the utilization and actual cost for the in lieu of service in rate setting, unless otherwise prohibited by Federal law.

## Service Coordination

### Service Coordination Program Overview

1. The CONTRACTOR(S) shall be responsible for Service Coordination and continuity and continuation of care by establishing a set of Member-centered, goal-oriented, culturally relevant, and logical steps to ensure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Case Management, disease management, discharge planning, and transition planning are elements of Service Coordination for Members across all Providers and settings. Service Coordination shall also assist Members with addressing Social Determinants of Health and Independence.
2. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives:
3. Supports person-centered care.
4. Intervenes along a continuum of need from Preventive Care to addressing acute, complex, and chronic needs.
5. Integrates Behavioral Health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs).
6. Improves health Outcomes for the entire population.
7. Addresses the Social Determinants of Health and Independence, including housing, adequate nutrition, adequate environmental conditions, transportation and other social determinants.
8. Increases access to community-based LTSS.
9. Allows for maximum access to community supports.
10. Supplements but does not supplant natural supports.
11. Provides for conflict-free Case Management, service delivery and assessment as directed by Federal and State law, as well as State policy (per 42 CFR § 431.301(c)(1)(vi) and 42 CFR § 441.730(b)).
12. Ensures that all populations, depending on their needs, receive the appropriate level of Service Coordination.
13. Consists of Case Management, and Service Coordination functions and activities.
14. Ensures appropriate face-to-face monitoring or telehealth, depending on needs of the member.
15. The CONTRACTOR(S)’ Service Coordination program shall at a minimum include the following elements:
16. Process for screening and assessing Members
17. Process for identifying and enrolling Members into the Service Coordination program
18. Person-centered service planning process
19. Monitoring and oversight processes of Member’s services and health and welfare
20. Processes for transitions of care
21. Information and referral processes
22. A process for effectively communicating with the Member, their family, PCP, other Providers, and members of the Member’s interdisciplinary team.
23. The provision of trauma-informed care and other evidence-based practices as appropriate.
24. Subcontracting with local entities for the provision of community Service Coordination.
25. A process for establishing the necessary permissions from the individual to coordinate care among different Providers, and establishing the required HIPAA‑approved and 42 CFR § Part 2 compliant Business Associate Agreements (BAA) to address protected health information (PHI).
26. A process to assure referrals for medically necessary, specialty, secondary, and tertiary care and a person designated as primarily responsible for coordinating the health care services furnished to the Member.
27. A process to assure the provision of care in emergency situations, including an educational process to help assure that Members know where and how to obtain medically necessary care in emergency situations.
28. The CONTRACTOR(S) Service Coordination model requires at a minimum that the following groups be enrolled in Service Coordination:
29. Individuals enrolled on a 1915(c) Waiver or on a Waiver waiting list.
30. Youth (birth up through age 21) with intensive Behavioral Health needs.
31. Youth who are in and out of home placement through the foster care system.
32. Individuals who are institutionalized in a NF, ICF/IDD or hospital, psychiatric residential treatment facility, psychiatric hospital, or other institution.
33. Adults with Behavioral Health needs.
34. Individuals with chronic and/or complex physical and/or mental health conditions.
35. Individuals participating in the Work Opportunities Reward Kansans (WORK) program or Other Employment Programs.
36. Other individuals who the CONTRACTOR(S) determines would benefit from Service Coordination. The CONTRACTOR(S) shall use at a minimum information regarding Social Determinants of Health and Independence, such as housing instability, food insecurity, and unemployment/under employment in identifying other individuals who would benefit from Service Coordination. The CONTRACTOR(S) may also use other tools, including proprietary algorithms, to identify additional Members for Service Coordination. The CONTRACTOR(S) shall submit the criteria used for determining other Members who will receive Service Coordination to the State for review and approval.
37. The CONTRACTOR(S) shall provide a detailed description in its proposal of its model for Service Coordination and how its model meets the requirements described in Section 5.4. The CONTRACTOR(S) shall address at a minimum:
38. How it will engage Providers in the Service Coordination program and how the CONTRACTOR(S) will build working relationships with needed Providers and community organizations.
39. How it will engage Members to participate in the Service Coordination program, including any incentives it would propose utilizing, and why it believes those incentives will be effective.
40. CONTRACTOR(S)’ experience in working with PCPs and Behavioral Health Providers to facilitate a high degree of coordination and communication of care across disciplines for the benefit of its Members.
41. How it will engage Members and their physical, HCBS, LTSS, and Behavioral Health Providers under the CONTRACT to ensure optimal coordination and communication, including a description of best practices in this area and how the CONTRACTOR(S) proposes to address any barriers to integration.
42. How it will focus its integration efforts to get the most value, and what anticipated improved health Outcomes for Members or improved compliance with established medical protocols it would expect based on its efforts to improve the integration of medical and Behavioral Health care.
43. What other Outcomes, in addition to health Outcomes, it would expect to improve and monitor.
44. What type of clinical support it will offer to Providers treating Behavioral Health conditions (including but not limited to depression, anxiety and addiction) in the Primary Care setting.
45. How it will promote and support Primary Care based Behavioral Health in pediatric and adult populations; what best practices and recommended protocols it will use to support the integration of medical and Behavioral Health care; and what materials and tools it will utilize in order to engage Members and Providers to improve integration.
46. How it will engage Members in order to obtain consent to share PHI across physical health, Behavioral Health, HCBS, and LTSS care Providers, when such consent is required, and its previous experience in obtaining Member consent, particularly as it relates to 42 CFR § Part 2 for SUD care.
47. How CONTRACTOR(S) will assist Members with addressing Social Determinants of Health and Independence.
48. Examples of innovative network designs or structures that it has tested or implemented, if any, to facilitate integration of medical and Behavioral Health care services, and any direct improvements that resulted. CONTRACTOR(S) will provide designs or structures to support the development of high-functioning interdisciplinary teams for high-risk members.
49. How CONTRACTOR(S) will improve health outcomes, reduce placements and reduce use of psychotropic medication for children in foster care.
50. How CONTRACTOR(S) will reduce use of psychotropic medication for nursing home residents.
51. How CONTRACTOR(S) will ensure that Medicare-funded healthcare services are coordinated and maximized for populations including HCBS Waiver populations,
52. How CONTRACTOR(S) will engage with and CONTRACT with local organizations to provide community services.
53. How CONTRACTOR(S) will ensure conflict of interest is mitigated when Subcontracting Community Service Coordination.

### Health Screening, Health Risk Assessments, and Needs Assessments

1. The CONTRACTOR(S) shall have processes in place to identify and address Behavioral Health, physical health, and LTSS needs of all Members. The CONTRACTOR(S) shall implement processes to assess, monitor, and evaluate services to all subpopulations and shall ensure appropriate referrals and follow up take place as a result of any screening or assessment activity. Please refer to the Service Coordination workflow in Attachment K.
2. The CONTRACTOR(S) shall make reasonable efforts (three [3] attempts via phone and then follow up by mail within ten [10] business days from date of enrollment for new Members) to contact Member in person, by phone, or by mail to complete Health Screening and Health Risk Assessments (HRAs). If unable to reach the Member, the CONTRACTOR(S) shall attempt screening again, at a minimum, every ninety (90) days or following HCBS Waiver requirements. The CONTRACTOR(S) shall use methods beyond the typical phone and mail to reach the Member, including hard-to-reach Members, but not limited to, contacting through a Provider or other community partner, etc. Describe alternate methods the CONTRACTOR(S) will utilize to reach those hard-to-reach Members. Hard to reach means those without a phone, identified as homeless, etc.
3. The CONTRACTOR(S) shall ensure that Member’s immediate needs are met and shall perform screens, HRA, needs assessment, PAs, etc. in an expedited manner to ensure a Member’s health and welfare.
4. The CONTRACTOR(S) shall operate and maintain a centralized information system necessary to conduct Health Screening, HRAs, and needs assessments. The system shall include the capability of collecting and reporting short-term and intermediate Outcomes such as Member risk level and change. The system shall be able to collect and query information on individual Members as needed for follow up and to determine intervention Outcomes and shall be capable of interfacing with the State’s Kansas Modular Medicaid System.
5. Health Screening:
6. The CONTRACTOR(S) shall propose a plan to conduct initial Health Screenings for all Members within ninety (90) days of enrollment or as directed by HCBS Waiver or State policy for LTSS and Behavioral Health Members, whichever is less.

The State may make changes to the Health Screening process in the near future. The CONTRACTOR(S) shall make system and process updates required by the State and must work with the State on implementing any new processes with an agreed upon turnaround time related to Health Screening of KanCare Members.

1. The CONTRACTOR(S) shall complete Health Screenings for new Members telephonically or in person using a screening tool that contains State prescribed questions and fields.
2. The CONTRACTOR(S) shall complete the Health Screening for existing Members using historical claims data, telephonically, or in person. Members who are enrolled in a HCBS Waiver or have an identified Behavioral Health need shall have their Health Screen completed in person and, if indications of further needs assessment are present, the CONTRACTOR(S) shall complete the HRA and/or other needs assessments while in the home.

The CONTRACTOR(S) must complete the Health Screen via telephone or in person at least every other year. The CONTRACTOR(S) may only complete the Health Screen via claims data every other year.

1. The Member shall be offered assistance in arranging an initial visit with their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Member’s potential risk, if any, for specific diseases or conditions.
2. The CONTRACTOR(S) shall update the Health Screen at least annually through phone assessment, PCP, or claims data.
3. The CONTRACTOR(S) shall utilize a State developed Health Screen and algorithm, similar to the one found in Attachment F, which includes scoring Members who are participating in a Health Screen telephonically or in person. The State will be working towards finalizing the Health Screen and algorithm prior to the execution of the CONTRACT.
4. HRAs and Needs Assessment:
5. The CONTRACTOR(S) shall conduct HRAs (per requirements at 42 CFR § 438.208(b)(3)) on all Members whose Health Screen results indicate the need for an HRA, using the State developed tool similar to the one found in Attachment E, within 30 days of the completion of the Health Screen or as directed by HCBS Waiver or State policy for LTSS and Behavioral Health. Members with LTSS and Behavioral Health needs shall be assessed with 14 days of enrollment. The HRA will determine the type of needs assessment warranted by the Member’s health status and next steps in the process. The HRA shall be performed in person. If the HRA cannot be performed in person, the CONTRACTOR(S) shall submit the rationale to the State and perform the HRA in an alternative manner with State approval. The State will be working towards finalizing the HRA prior to the execution of the CONTRACT.
6. The CONTRACTOR(S) shall complete identified needs assessments as indicated by the HRA, in person, within fourteen (14) days of the completed HRA or as directed by HCBS Waiver or State policy for LTSS and Behavioral Health. (See 42 CFR § 438.210(b)(2)(iii) for requirement for LTSS.)

The CONTRACTOR(S) shall use the State prescribed tool designated for each Waiver program for the assessment of HCBS needs after the Member has been determined functionally eligible for the Waiver program.

The CONTRACTOR(S) shall use the State prescribed tool for the assessment of Behavioral Health needs.

The CONTRACTOR(S) shall submit additional needs assessments that target specific populations such as pregnant women, children with special health care needs, etc.

1. The CONTRACTOR(S) shall reassess a Member’s need for services at least every 365 days from the date of the last assessment or more frequently as a Member’s needs change.

The MCO service coordinator or community service coordinator will note in the Member’s record within one (1) business day of notification of the Service Coordinator or Community Service Coordinator of a significant change in condition.

A reassessment of the Member’s needs will take place within three (3) calendar days of discovery or notice of significant change in condition or needs. The Person Centered Service Plan (PCSP) will be dictated by State policy or HCBS Waiver, whichever is more restrictive, for HCBS Members. The reassessment can be an update to existing information in the HRA or needs assessment or a new assessment. The PCSP shall be updated to include any new required goals, interventions, or service authorizations for the Member and shall be signed by the Member, his or her guardian, Providers and other relevant parties in accordance with PCSP requirements set forth in Section 5.4.4 or as dictated by State policy for the PCSP or the HCBS Waiver.

Actions taken (e.g., referrals to community agencies, authorizations of new services, etc.) by the CONTRACTOR(S) that were a result of a significant change in condition will be communicated to the Member and documented in the Member’s record within four (4) business days of the significant change event to ensure appropriate communication of the event to the service coordinator or as specified in the State’s policy.

1. The CONTRACTOR(S) shall implement a State approved referral process for Service Coordination as indicated by the results of the HRA and needs assessments.
2. Members identified as meeting Service Coordination criteria are referred for further assessment of level acuity as well as Provider referral for services as needed.

The CONTRACTOR(S) will provide the State data derived from the Health Screen, HRA, Needs Assessment, and PCSP by individual thirty (30) days after completion. This will be provided to the State in a format prescribed by the State and will be transmitted to the State through the Upload Utility Tool for storage in the KDHE Enterprise Data Warehouse.

### Long-Term Services and Supports Functional Eligibility Determinations

The CONTRACTOR(S) shall make referrals to the appropriate conflict-free entities for determinations of functional eligibility for enrollment in HCBS Waiver programs and/or Admissions to any and all Adult Care Homes, including, but not limited to, NFs and/or ICF/IDD within two (2) business days of determining a possible need for LTSS. After a referral is made, CONTRACTOR(S) must follow-up with the referred entity per HCBS Waiver requirement to ensure the entity has either scheduled or completed the functional assessment.

### Plans of Service and Person-Centered Service Planning

The CONTRACTOR(S) shall meet all requirements in Section 5.4.4.1 – Plans of Service for KanCare Members who receive Service Coordination. Additionally, Members enrolled in HCBS Waiver services, children in foster care and Members with Behavioral Health needs shall receive Person Centered Service Planning (PCSP) required in Section 5.4.4.2 – Person Centered Service Planning.

#### Plans of Service

The Plan of Service is a written document that describes and records the Member’s goals and service needs in accordance with State policy. The Plan of Service records the strategies to meet goals and interventions selected by the Member and team to support them in improving the Member’s health and wellbeing and addressing Social Determinants of Health and Independence.

1. The CONTRACTOR(S) shall ensure that all members receiving Service Coordination are able to participate in a Plan of Service planning process. The Plan of Service shall accurately document the Member’s strengths, needs, goals, lifestyle preferences, and other preferences and outline the services and supports that will be provided to meet their identified needs through services provided or coordinated by the CONTRACTOR(S). The CONTRACTOR(S) shall also consider the availability and role of unpaid supports provided by family members and other natural supports.
2. The CONTRACTOR(S) shall provide to the State for approval, a description of its Plan of Service process and samples of all instruments to be used.
3. The CONTRACTOR(S) shall ensure that the Plan of Service is written in easily understood language and addresses the assessed needs of the Member by identifying all services and supports that will be provided, including those provided voluntarily by natural supports, services delivered by medical and professional staff, and by community resources or Providers.
4. The Plan of Service must be compliant with the State’s Plan of Service policy, and shall include the following components:
5. A description of the Member’s goals, strategies to meet goals and desired health, functional and quality of life Outcomes. For youth Members, inclusion of their family’s goals and strategies shall be incorporated into the Plan of Service.
6. Member’s identified strengths, preferences, and any identified needs including psycho-social needs and needs related to social determinations of health and independence such as housing or financial assistance.
7. Any services authorized including a detailed description of the amount, scope, and duration of services needed to help meet identified needs or to achieve goals.
8. Risk factors, including a Member’s understanding of risk factors and potential adverse consequences, Member’s plans to respond to adverse consequences, and additional measures in place to minimize them, when needed.
9. Level of Service Coordination.
10. Providers and contact numbers.
11. Support systems, relation to Member, and contact numbers including emergency contact.
12. Medication list with date and dosages.
13. Pharmacy and number.
14. Primary language.
15. Cultural considerations.
16. Treatment plan as appropriate.
17. Date of next Service Coordination contact.
18. Date of annual reassessment.
19. Backup plan per requirements found in 42 CFR § 441.450.
20. Patient liability and/or client obligation information including information about Providers to whom the Member has paid.
21. The Member’s eligibility start and end date.
22. Any specialized communication needs including interpreters or special devices required by the Member. This includes an identification of any reading challenges.
23. Any medical equipment used or needed by the Member.
24. The Member’s physical environment and any modifications necessary to ensure the Member’s health and safety.
25. Identification of who is monitoring the plan.
26. Service coordinator name and direct contact information along with appropriate off-hours contact information.
27. The CONTRACTOR(S) shall use their own form for the Plan of Service that is user friendly for the Member, as long as all data elements described in Section 5.4.4.A.1-22 are included. The State reserves the right to require the CONTRACTOR(S) to use a form prescribed by the State. The CONTRACTOR(S) form shall be called the Plan of Service.
28. The CONTRACTOR(S) shall ensure that the Plan of Service is developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting.
29. The CONTRACTOR(S) must develop a process by which the Plan of Service is signed and approved and must comply with the following requirements.
30. The Plan of Service must be completed with all required data elements prior to the signature process.
31. The Plan of Service must be signed by the Member, their MCO service coordinator, community service coordinator, and any Providers present during the development of the Plan of Service.
32. The Plan of Service cannot be implemented until at a minimum the service coordinator, the community service coordinator, and Member’s signature is obtained unless an extraordinary circumstance prevents signatures from being obtained as indicated by State policy.
33. The CONTRACTOR(S) shall ensure that the Plan of Service is reviewed during every contact with the Member and updated with new signatures obtained as prescribed at least annually or more often based on changes on Member’s needs.
34. Members shall be provided a choice of paper or electronic Plan of Service prior to development of the plan. A completed Plan of Service must be provided to the Member prior to services beginning.

#### Person Centered Service Planning

The Person Centered Service Plan (PCSP) is a written service plan developed in accordance with the person centered planning requirements set forth in Federal regulations and State policy. The PCSP is a written document that describes and records the person centered Member’s goals and service needs. The PCSP records the strategies to meet the goals and interventions selected by the Member and team to support them in improving the Member’s health and wellness and in addressing Social Determinants of Health and Independence.

1. For all Members enrolled in HCBS waiver services, children in foster care and Members with Behavioral Health needs, the CONTRACTOR(S) shall ensure that Members are able to participate in a PCSP process that is compliant with federal and state law and the State’s PCSP policy. The Contractors will ensure the PCSP includes the use of an interdisciplinary team of professionals including individuals chosen by the participant. The professionals must have adequate knowledge, training and expertise around community living and person-centered service delivery. The process must promote self-determination and actively engage the participant and individuals of their choice. The State will establish a PCSP policy, and the CONTRACTOR(S) shall acknowledge its intent to abide by the requirements of the policy once it is approved. Once implemented, CONTRACTOR(S) will work with the State on developing acceptable timelines for compliance with the policy.
2. The CONTRACTOR shall comply with applicable State and Federal rules (42 CFR. §, 441.301(c) and K.A.R. 30-63-1 Article 63) when developing the PCSP and associated assessments. The CONTRACTOR(S) shall provide to the State for approval a description of the PCSP process and samples of all instruments to be used.
3. The CONTRACTOR(S) must develop a process by which the PCSP is signed and approved and must comply with the following requirements.
4. The PCSP must be completed with all required data elements prior to the signature process.
5. The PCSP must be signed by the Member, guardian, or legal representative, the MCO service coordinator, the community service coordinator, and all Providers listed on the PCSP.
6. The PCSP cannot be implemented until at a minimum the service coordinator, the community service coordinator, and Member’s signature is obtained unless an extraordinary circumstance prevents signatures from being obtained as indicated by State policy.
7. The CONTRACTOR(S) shall ensure that the PCSP is reviewed during every contact with the Member and updated at least annually or more often based on changes to Member’s needs.
8. The CONTRACTOR(S) shall be responsible for approving the PCSP as well as approving the amount, scope, and duration of services contained within the timeframes described in Section 5.4.4 H.
9. The CONTRACTOR(S) shall demonstrate its processes and procedure to ensure that their contracted community service coordinator works with the Member and their interdisciplinary team on developing the PCSP that includes recommendations regarding amount, scope, and duration of services. The community service coordinator is also responsible for monitoring the implementation of the plan and updating it as needed.
10. The CONTRACTOR(S) shall ensure all required signatures for the PCSP are collected and are available to the State upon request.
11. The CONTRACTOR(S) shall ensure that the HCBS needs assessment and the development of the PCSP with signatures occurs and that the approved, signed plan is distributed to Members of the interdisciplinary team within fourteen (14) days of the establishment of waiver eligibility.

### Service Coordination Stratification Levels and Contact Schedules

The CONTRACTOR(S) shall develop and implement a State approved Service Coordination program that promotes person-centered care and improved health Outcomes for all KanCare Members, addresses all of the goals of the Service Coordination program, and includes a system of monitoring and oversight of the Service Coordination program.

As part of the Service Coordination program, the CONTRACTOR(S) shall assign to each Member participating in the Service Coordination program a single point of contact and provide a direct telephone number and email address for contact during business hours. For after hours, the Member will be directed to use the nurse line or afterhours service and provided this contact information.

The Service Coordination program shall include four levels of Service Coordination based on the Member’s needs as a result of the HRA and Needs Assessments. The CONTRACTOR(S) shall use the following criteria as the basis for assigning Members to a stratification level but may add additional criteria as approved by the State. The four levels are:

1. Level I – Member Education/Resourcing: Members in need of health education, information on Wellness services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) information, and periodicity schedules.
2. Level II – Short-Term/Transition of Care Needs: Members require intermittent specific assistance, including discharge planning from a short-term acute stay. Examples:
3. Member is moved from one level of care or service to another.
4. Member has moved from one CONTRACTOR(S) to another or from Fee-for-Service (FFS) to CONTRACTOR(S).
5. Discharge from hospital after a short-term stay.
6. Level III – Chronic Long-Term Needs: Members identified with chronic conditions in need of long-term Service Coordination including, but not limited to, all Members residing in the community enrolled in a HCBS Waiver program.
7. Level IV – Complex/High Risk: Members in need of more frequent, intensive Service Coordination including, but not limited to, youth with Behavioral Health conditions and their families who require intensive Service Coordination through a High Fidelity Wraparound approach, individuals with complex needs or homeless.
8. Youth in foster care and Members discharged from a long-term stay in a hospital, State hospital, public or private ICF/IDD, psychiatric residential treatment facility (PRTF) or other institutional setting shall be placed in either Level III or Level IV of Service Coordination based on their individual needs.
9. The CONTRACTOR(S) shall re-evaluate the appropriateness of Member’s Service Coordination level, in person, at least annually or more often based on changes in the Member’s needs or circumstances, upon request of the Member, the Member’s legal guardian, or legal representative,
10. Service Coordination contacts: The CONTRACTOR(S) shall make contacts (telephonic or face-to-face) with the Member based on the Members needs and shall describe how it will comply with the following minimum contact schedule based on the Member’s assigned Service Coordination stratification level. At a minimum, each Member receiving Service Coordination will receive an in person contact by the CONTRACTOR(S) staff or a Provider within their network) during either a Service Coordination touch point meeting or other activity:
11. Level I – Member Education/Resourcing:

Annual contact with any Provider contracted with the CONTRACTOR(S)

Additional contact as determined by the CONTRACTOR(S) to meet the Member’s needs.

If there is no contact with the Member by anyone contracted with the CONTRACTOR(S) in a twelve month period, the CONTRACTOR(S) shall follow up with the Member within thirty (30) days of the discovery of a lack of contact, directly by any means necessary to make contact with the Member.

The CONTRACTOR(S) shall make available their contact schedule methodology upon request from the State.

1. Level II – Short-Term/Transition of Care Needs:

As determined by the CONTRACTOR(S) to meet the individual’s needs but includes at least one face-to-face visit after discharge along with necessary telephonic contacts needed to ensure continuity of care. After discharge at a minimum one face-to-face visit by the service coordinator at least annually.

The CONTRACTOR(S) shall make available their contact schedule methodology upon request from the State.

1. Level III – Chronic Long-Term Needs:

At a minimum monthly telephonic contact and with a minimum of a face-to-face visit every three (3) months.

1. Level IV – Complex/High Risk:

At minimum monthly telephonic contacts and a face-to-face visit every other month.

* + - 1. Contacts for all levels can be made by any member of the Member’s interdisciplinary team. The results of the contact and notes about the meeting must be documented in the Member’s electronic record.

### Managed Care Organization Service Coordination Roles and Responsibilities

1. The CONTRACTOR(S) approach to Service Coordination (model of care) must contain the features of a high-performing Care Management system including but not limited to:
2. Person and family centeredness.
3. Timely, proactive, and planned communication and action.
4. The promotion of self-care and independence.
5. Emphasis on cross continuum and system collaboration and relationships.
6. Comprehensive consideration of physical, behavioral, and Social Determinants of Health and Independence.
7. Promotion of community access and participation for Members at-risk for isolation or who encounter barriers to participating in community activity.
8. The CONTRACTOR(S) is ultimately responsible for all Service Coordination activities below and displayed in Attachment L, and shall ensure the following tasks are performed:
9. HRAs and Needs Assessment for those populations not Subcontracted to the community service coordinator.
10. Approving PCSPs and Plans of Service including the amount, scope, and duration of any services included in the plan for all Members, including those populations Subcontracted to the community service coordinator.
11. Coordination of physical health, Behavioral Health, LTSS and transportation needs, as appropriate.
12. For Members residing in institutional settings the coordination of services external to the facility.
13. Serving as a resource to the community service coordinator entity by providing information about the Member’s utilization of services.
14. For children and youth involved in foster care system, coordination with Child Welfare CONTRACTOR(S)’ case managers.
15. For Members with chronic/complex conditions and other Members who the CONTRACTOR(S) has identified as in need of Service Coordination who do not fall into another Service Coordination population, the CONTRACTOR(S) shall:
    1. Develop, implement, monitor and approve the Plan of Service
    2. Provide choice counseling
    3. Conduct Member contacts and home visits
    4. Provide linkage and referral to community resources and non-Medicaid supports
    5. Monitor health and safety
    6. Provide support education, employment and housing, including making referrals, advocacy and follow-up.
16. The CONTRACTOR(S) must Subcontract with local entities (community service coordinators) to perform community Service Coordination activities as described in Section 5.4.7. The CONTRACTOR(S) shall support community service coordinators entities by:
17. Delineating responsibilities between the community Service Coordination entity and the MCO Service Coordination in order to avoid duplication or gaps in services.
18. Maintaining a single CONTRACTOR point of contact for the community service coordinator.
19. Establishing a protocol for the transmission of requested data, information, and reports in a timely manner.
20. Responding to requests from the community service coordinators for assistance or support in a timely manner.
21. Ensuring CONTRACTOR(S) and local entities meet conflict of interest requirements, as identified in Section 5.4.13.
22. The CONTRACTOR(S) shall develop a contingency plan for when there are short-term gaps in community Service Coordination capacity and must notify the State upon activation of the contingency plan. The CONTRACTOR(S) shall work to build capacity in the local community for community Service Coordination. The CONTRACTOR(S) shall document, and make documentation available to the State upon its request, its attempts to contract with community-based organizations for the provision of community Service Coordination.

### Community Service Coordination Roles and Responsibilities

1. The community service coordinator shall serve as the single point of contact for the Member. The CONTRACTOR(S) shall provide oversight of its contracted community service coordinators to ensure that the following activities outlined in Attachment L and below are performed:
2. Development, implementation, and monitoring of the PCSP and Plan of Service for certain population as directed by the CONTRACTOR(S).
3. Completion of screening, HRAs, and other needs assessments for certain populations as directed by the CONTRACTOR(S).
4. Choice counseling including the exploration of interest/ability to move to a community setting for individuals residing in institutional settings.
5. Implementation of “treatment plan” component of PCSP and Plan of Service as appropriate.
6. Member contacts and home visits.
7. Linkage and referral to community resources and non-Medicaid supports.
8. Health and safety monitoring.
9. Support for education, employment and housing, including, but not limited to, making referrals, advocacy and follow up.
10. Education of the Member about self-direction and the WORK program and Other Employment Programs, and support of the Member who chooses to self-direct certain HCBS and WORK services.
11. For children enrolled on the Autism waiver or who are diagnosed with a SED intensive Case Management (RADAC) as well as High Fidelity Wraparound services, as well as monitoring and follow-up consistent with evidence based wraparound services and system of care grants.
12. Comply with all requirements described in K.A.R. 30-63-32-Articles 63 and 64 when providing community support coordination to individuals with IDD.
13. For individuals in nursing homes, ICF/IIDs, the CONTRACTOR(S) shall provide:
14. Transition coordination/transition planning
15. Support and education facility on pharmaceutical approaches
16. For individuals in hospitals and other institutional settings, the CONTRACTOR(S) shall provide:
17. Transition coordination/transition planning
18. Assisting in discharge planning and securing appropriate community services
19. The CONTRACTOR(S) may use a team approach where non-clinicians may perform certain tasks, including, but not limited to, confirmation of Provider appointments, scheduling home visits, arranging transportation, and facilitation of distribution of the service plan to the Member and Providers.
20. The CONTRACTOR(S) may provide or Subcontract with a certified peer support Provider as part of the Service Coordination team:

The certified peer support Provider may:

Help the Member develop a recovery social network for information and support from others who have been through similar experiences.

Assist the Member with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses, or treatment with his or her clinician.

Assist the Member to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments.

* + 1. The CONTRACTOR(S) may provide or Subcontract with a certified Positive Behavioral Support (PBS) facilitator as part of the services for the Service Coordination team:
  1. The certified PBS facilitator may provide EPSDT service to anyone under age 21 who is recommended by physician or licensed professional with PA based on medical necessity.
     1. The certified PBS facilitator may provide:

1. PBS Assessment: To include a functional behavior assessment, interviews and observations in multiple settings, use of PBS tools to conduct PBS assessment based on national standards.
2. Person-Centered Planning: A service provided by a certified PBS facilitator and driven by Member/family along with natural supports to prevent and decrease likelihood of more significant challenging behaviors. This process results in a behavioral plan that is goal and objective driven with incorporation of health, medical, and psycho/social, outlining quality of life and independence indicators, highlighting strengths, appropriateness of environment, activities and rate of reinforcement/or corrective feedback.
3. PBS Treatment: A preventative service to provide goal‑directed supports and solution focused interventions as set forth in PBS Person-Centered Plan. PBS Treatment is a face-to face intervention with the Member present. The majority of PBS Treatment must occur in community settings where the Member lives, works, and socializes. PBS interventions are prevention-based strategies which include antecedent interventions, ongoing assessment and cueing, and modeling behavior alternatives.

### Qualifications for Service Coordinators

The CONTRACTOR(S) service coordinators shall have experience that is appropriate to the Member’s health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/ credentialing rules. The CONTRACTOR(S) has the flexibility to determine the service coordinator qualifications for populations not specifically listed here. Service coordinators working with specific populations shall have specific qualifications. CONTRACTOR(S) and community service coordinators serving Members who are in multiple population groups, such as youth in foster care who are enrolled on a HCBS Waiver, shall be assigned service coordinator most appropriate for the Member’s needs and have experience working with the populations to be served.

At minimum qualifications shall include:

1. For Members with a LTSS need, CONTRACTOR(S) and community service coordinators shall:
2. Have at least a bachelor’s degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN).
3. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific Waiver population (e.g. IDD, TBI or Frail Elderly [FE]), at least one (1) years’ experience working directly with that population. Full-time experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for service coordinators working with individuals with IDD. Additionally, community service coordinators providing services to individuals with IDD must meets qualifications described in K.A.R. 30-63-32-Article 63.
4. Comply with additional qualifications as described in the State’s HCBS Waivers included in Attachment C of this RFP.
5. For Members with a Behavioral Health need, CONTRACTOR(S) and community service coordinators shall:
6. Have at least a bachelor’s degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN.
7. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma informed care.
8. For youth in custody through the foster care system, CONTACTOR(S) and community service coordinators shall:
9. Have at least a bachelor’s degree in social work, nursing, psychology or related health and human services area or be a RN.
10. Have at least one (1) year of experience working with individuals with multi-system children.
11. Receive training in trauma informed care.

### Service Coordination Ratios

1. The CONTRACTOR(S) shall employ a methodology for assigning consistent and appropriate caseloads for CONTRACTOR(S) and community service coordinators and that ensures health, welfare, and safety for Members. The CONTRACTOR(S) must submit the methodology to the State for review and approval and must incorporate the following factors into its caseload assignment methodology:
2. Population
3. Acuity status mix
4. Service coordinator qualifications, years of experience, and responsibilities
5. Provision of support staff; location of service coordinator (community, CONTRACTOR(S) office, Provider office)
6. Geographic proximity of service coordinators to Members (if community based)
7. The CONTRACTOR(S) shall ensure if the CONTRACTOR service coordinator or community service coordinator is part of a Behavioral Health team where staffing ratios are part of a fidelity model that their staffing ratio comports with the fidelity requirements.
8. The CONTRACTOR(S) shall ensure there is a method to evaluate caseload assignments quarterly, including identification of circumstances that automatically trigger a review or adjustment of caseload sizes. Once evaluated, the CONTRACTOR(S) must make changes to coincide with ratio requirements.
9. The CONTRACTOR(S) shall ensure that caseload assignment provides for the name and telephone number of the Members, assigned CONTRACTOR and community service coordinator, along with an alternative number the Member may use in case their assigned service coordinator is in the field. For evening and weekend coverage, alternative numbers may be used with the expectation that the service coordinator or their designee will follow up with the Member in forty-eight (48) hours.
10. The CONTRACTOR(S) shall ensure that Members are notified via telephone or by mail of any CONTRACTOR(S) or community service coordinators departure at least seven (7) days in advance of the coordinators last day, if the MCO had advance notice of the staff’s departure, and shall provide name and number of alternative contact until a new service coordinator is assigned.
11. The CONTRACTOR(S) shall assign a new CONTRACTOR service coordinator or community service coordinator and must ensure the Member is contacted within three (3) business days of new assignment.
12. A team approach may be used to meet Service Coordination needs as long as the Member has a single point of contact.
13. The CONTRACTOR(S) shall submit a staffing plan for the Service Coordination program that includes a description of how they will monitor Service Coordination vacancies.
14. The CONTRACTOR(S) shall provide updates to the plan monthly with information about positions filled and those left open.
15. As part of its model of care description the CONTRACTOR(S) must address the following:
16. Its internal process (e.g. criteria for making assignment, notifications, information and data sharing, training, etc.) when a CONTRACTOR(S)’ service coordinator or community service coordinator resigns or has an assignment change.
17. Its turnover rates for service coordinators.
18. Its average level of education for your service coordinators.
19. Its process for determining the appropriate size of service coordinator caseloads and how it monitors them.

### Service Coordination Training Requirements

The CONTRACTOR(S) shall develop a comprehensive onboarding and training program to be completed within the first ten (10) days of employment for all Service Coordination and contracted community Service Coordination staff that has the following components:

1. A dedicated staff trainer who ensures that all training requirements are met.
2. A detailed Service Coordination training plan describing how the CONTRACTOR(S) will meet the initial, annual, and ongoing training requirements.
3. An initial training curriculum that at a minimum includes:
4. The CONTRACTOR(S)’ model of care
5. Cultural competency
6. PCSP and Plan of Service, as appropriate
7. Grievance and Appeals reporting, processes, and procedures
8. Availability of community resources in the service coordinator’s respective geographic areas
9. Care Management strategies for disease specific processes
10. Abuse/neglect/exploitation recognition and mandated reporter requirements, and reporting requirements and use of the State’s Adverse Incident Reporting (AIR) system
11. HIPAA
12. Clinical assessment and documentation
13. Interviewing, asking appropriate questions
14. Medication monitoring
15. Members’ rights and responsibilities
16. Medicaid Fraud
17. Trauma informed care
18. Social Determinants of Health and Independence
19. Advance Directives and legal designations (guardian, power of attorney, representative payee, etc.)
20. K.A.R. 30-63-1 through 30-63-32 addressing training requirements for the IDD populations
21. An annual training curriculum that includes at a minimum:
22. Cultural competency
23. Person-centered service planning
24. Grievance and Appeals reporting, processes, and procedures
25. Abuse/neglect/exploitation recognition, mandated reporter requirements, and associated reporting requirements
26. HIPAA
27. Medicaid Fraud
28. Trauma informed care
29. Social Determinants of Health and Independence
30. The CONTRACTOR(S) shall conduct an ongoing evaluation of the success of training and assessment for the need for additional training.

### Special Needs Populations

In addition to the requirements set forth in Section 5.4 of the RFP, the CONTRACTOR(S) shall meet the following requirements for the special needs populations defined below.

1. Children in Foster Care:
2. The CONTRACTOR(S) shall designate a foster care liaison who can serve as the point of contact for children’s services agencies.
3. The CONTRACTOR(S) shall ensure service coordinators who are working with foster children are aware of the roles and responsibilities of children’s services agencies vs. foster parent in making decisions on behalf of the child and shall provide specialized training as needed.
4. The CONTRACTOR(S) shall assure continuity of care, including, but not limited to, continuity in MCO and community service coordinators for children moving from one placement setting to another.
5. The CONTRACTOR(S) shall make a home visit within forty-eight (48) hours of placement when there is a change in placement.
6. The CONTRACTOR(S) shall ensure that an interdisciplinary team meeting (consisting of at a minimum, the MCO service coordinator, the foster parent, the children’s services case manager, and the Behavioral Health treatment Provider [if one]) are held via phone or in person within seven (7) days of a new and/or change in placement.
7. The CONTRACTOR(S) must provide in their Service Coordination model description of how they work with children with complex needs, including, but not limited to, children who have had multiple foster care placements or who are involved with multiple systems of care.
8. Children with Intensive Behavioral Health Needs:
9. The CONTRACTOR(S) shall ensure that the MCO and community service coordinators working with youth with Behavioral Health conditions and their families who require intensive Service Coordination through a High Fidelity Wraparound approach comply with all training, educational, and treatment requirements required by the evidence-based practice.
10. The CONTRACTOR(S) shall work to ensure there are alternatives available to children with SED residing in PRTFs, by providing services in the least restrictive settings.
11. Adults with Behavioral Health Needs:
12. The CONTRACTOR(S) must ensure protocols, policies, and processes are in place for service coordinators to appropriately address Member contacts related to Behavioral Health crisis needs.
13. Protocols must include, at a minimum, how the service coordinator will refer Members to Behavioral Health Services and timeframes for updates in the PCSP or Plan of Service that ensures the Member’s health and safety needs are met.
14. The CONTRACTOR(S) must develop procedures for cross training and consultation for service coordinators and community-based Behavioral Health Providers in order to facilitate continuity of care and cost-effective use of resources.
15. The CONTRACTOR(S) shall develop policy and procedures for obtaining releases to share clinical information and providing health records to community-based Behavioral Health Providers as requested, consistent with State and Federal confidentiality requirements.
16. The CONTRACTOR(S) shall facilitate the sharing of information, including PCSPs or Plans of Service and transitional services between the service coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service Providers, and the PCP.
17. The CONTRACTOR(S) shall assist individuals with accessing safe and sustainable housing and must either employ or contract for a housing specialist to help support these efforts.
18. Individuals in Institutional Settings:
19. The CONTRACTOR(S) shall assign a service coordinator to all individuals residing in institutions (NF, hospital, private or public ICF/IIDs, State hospital, psychiatric residential treatment facility). A service coordinator shall also be assigned to all individuals residing within a State correctional facility once the individual receives a Tier 1 Presumptive Medical Determination from KDHE.
20. The CONTRACTOR(S) assigns the Service Coordination stratification level that is most appropriate to meet the Member’s needs.
21. The CONTRACTOR(S) shall participate in, at a minimum, one Service Coordination meeting with the Member, their family, and the facility staff at least annually.
22. The CONTRACTOR(S) shall participate in, at a minimum, one Service Coordination meeting with the Member and correctional facility staff prior to the Member's discharge/release from a State correctional facility.
23. The CONTRACTOR(S) shall at least annually evaluate if the Member’s needs can be met in a less restrictive environment that includes assessing the Member’s interest in and ability to transition to the community and determine if the Member has an interest in transitioning to a community setting. Requests for evaluations may also come from the ombudsman (KanCare or LTC), Member, legal guardian, or other representative.
24. The CONTRACTOR(S) shall develop a transition plan to help support the transition to a less restrictive environment as appropriate. A transition plan shall also be created for Members discharging/releasing from a State correctional facility in conjunction with State corrections staff.
25. The CONTRACTOR(S) shall ensure supports are in place prior to the discharge and transition to new setting.
26. The CONTRACTOR(S) shall assist with helping the Member relocate to another facility if they express a desire to move or the quality of the current facility places a Member’s health and welfare at risk and ensuring all the necessary supports are available for a successful transition.
27. The CONTRACTOR(S) shall monitor the success of the Member’s community transition and ensure if enrolled in a HCBS program that the new setting is complaint with the CMS HCBS Setting Final Rule.
28. Individuals Enrolled in HCBS Waiver and WORK and Other Employment Programs:
29. The CONTRACTOR(S) shall provide all Members receiving HCBS Waiver services with the appropriate notice for any Adverse Benefit Determination. Such notification shall be provided as required by State and Federal regulations, Waiver requirements, and applicable KDHE and KDADS policy related to timely and appropriate notice as specified in Attachment D.
30. The CONTRACTOR(S) shall ensure that the Member’s PCSP or Plan of Service shall support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
31. The CONTRACTOR(S) shall timely recommend voluntary and involuntary closure for HCBS Waiver services to the appropriate State agency using the established notification process as described by the State. Reasons for voluntary and involuntary terminations as defined by the HCBS Waiver service notification of termination policy may include, but are not limited to:

Member has no assessed need for services upon assessment or reassessment.

Client obligation is higher than the cost of service as identified on the integrated service plan.

Member has refused to pay client obligation as documented by the Provider to whom the client obligation is to be paid or the Financial Management Services (FMS) Provider and verified by the service coordinator.

Member has refused services and supports identified on the integrated service plan as documented and signed by the Member and/or guardian.

Member has been institutionalized for longer than the temporary care period of time (the month of Admission and two [2] subsequent months) and is no longer eligible for services.

Member is unable to be located or fails to respond per requirements in Section 5.4.11.E.4, to attempts to locate for initial or annual assessment for services.

Member refuses to sign the PCSP, the Plan of Service or the WORK Individualized Budget.

Member is no longer receiving services under the LTSS program.

Member has requested termination of services.

Member cannot be contacted or does not respond to reasonable attempts to contact the Member as required by the notification of termination policy.

1. Termination for the inability to contact an LTSS Member regarding initial or annual assessments for services and supports shall be documented according to the notification of closure policy. The CONTRACTOR(S) shall make three (3) attempts to contact the Member, including a minimum of one (1) home visit. All contacts shall be attempted within fourteen (14) business days from the date of the initial attempt to contact the Member. If unsuccessful, the CONTRACTOR(s) will notify the KanCare Ombudsman and request assistance. If all attempts to contact the Member by the CONTRACTOR or KanCare Ombudsman prove unsuccessful, the CONTRACTOR(S) shall notify the appropriate State agency using the established notification process as described by the State. The State agency may intervene to attempt contact with the Member, and all recommendations by the CONTRACTOR(S) must be approved by the State to issue a Notice of Action providing the Member ten (10) days’ notice of the impending closure. The Notice of Action shall be mailed to the Member’s last known address. The CONTRACTOR(S) shall provide the State with the appropriate notice recommendation to close the services and supports for the Member.
2. Failure by the CONTRACTOR(S) to notify the State timely, as defined by the State of the need for closure of HCBS Waiver services, may result in liquidated damages leveraged against the CONTRACTOR(S).
3. The CONTRACTOR(S) shall ensure that MCO and community service coordinators who work with Members who fall into multiple special needs categories, e.g. foster children enrolled on a HCBS Waiver, comply with all requirements described in Section 5.4.11 as appropriate.
4. Should the CONTRACTOR(S) suspect that an inability to contact a Member is the result of any abuse, neglect or exploitation, the CONTRACTOR(S) shall make immediate referrals to the appropriate State agency for follow up and investigation.

### Care Transitions and Diversion Activities

The CONTRACTOR(S) must manage transitions of care between settings in order to prevent unplanned or unnecessary Hospital Readmissions, emergency department (ED) visits, and/or adverse Outcomes. Managing care transitions involves the right amount of assistance, at the right time, and for the right duration, to assist Members in receiving health maintenance services that holistically meet their physical health, mental/Behavioral Health, and/or LTSS care needs in the least restrictive setting.

1. The CONTRACTOR(S) shall at a minimum manage the following transitions:
2. Member is moved from one level of care or service to another
3. Hospital to NF
4. Hospital (e.g. State hospital, ICF/IID, etc.) to community
5. NF to community
6. Community to NF
7. Member’s assignment to an HCBS Waiver
8. Transfer from one facility-based Provider to another
9. Community to PRTF
10. PRTF to community
11. Community to hospital
12. Moved from one HCBS Waiver to another HCBS Waiver
13. Member moved from one CONTRACTOR to another
14. Member moving from FFS to managed care
15. Member moved into foster care placement
16. Member moved from one foster care placement to another
17. State correctional facility to community for beneficiaries who receive a Tier 1 Presumptive Medical Determination from KDHE-DHCF
18. Other critical stages in the Member’s life e.g. youth transitioning from school to work and/or adult services
19. As part of their care transitions process, the CONTRACTOR(S) shall at a minimum:
20. Develop a method for evaluating risk of Hospital Readmission in order to determine the intensity and urgency of follow up required for the Member after the date of discharge.
21. Regularly collaborate, communicate, and coordinate with the Member, their families/support persons/guardians, ED, LTSS, physicians, nurses, social workers, discharge planners, the discharging facility, service Providers, and schools as appropriate.
22. Establish a single point of contact for the Member’s transition activities.
23. Ensure that timely notification and receipt of Admission dates, discharge dates, and clinical information is communicated between internal CONTRACTOR(S)’ departments and between care settings, as appropriate.
24. Make referrals to, work with, and leverage resources from any existing transition programs as appropriate.
25. Evaluate a Member’s need for LTSS and pursue the least restrictive environment for the individual, taking into consideration the Member’s preferences. The CONTRACTOR(S) shall make referrals for HCBS Waiver eligibility and/or NF placement to the appropriate entities.
26. Participate in discharge planning activities with the facility, including making arrangements for safe discharge placement, facilitating clinical hand-offs between the discharging facility and the CONTRACTOR(S), and ensure adequate housing and income support are available to the Member.
27. Provide sufficient information and support to ease the transition by addressing the Member’s understanding of medications, self-management, rehabilitation activities, LTSS, employment, independence, etc.
28. Schedule appointments and follow up with Members if appointments are missed.
29. Evaluate the need to develop or revise the PCSP or Plan of Service in collaboration with the Member, Providers, caregivers, or other appropriate entities, with the Member’s consent.
30. Develop, or assist in the development of, or obtain a copy of an existing discharge/transition plan, and ensure that the transition/discharge plan and post‑discharge services are integrated into the Member’s PCSP or Plan of Service.
31. The transition/discharge plan activities includes, but are not limited to, the following elements:
32. Timeframes related to appointments, discharge paperwork, and aftercare (behavioral supports).
33. Follow-up appointment information.
34. Medication information to allow Providers to reconcile medications and make informed decisions about care.
35. Education on medications as well as education on any individual conditions and chronic diseases.
36. Therapy needs, e.g., occupational, physical, speech, etc.
37. Transportation needs.
38. Community supports needed post-discharge.
39. Determination of environmental (home, community, workplace) safety.
40. Arrange for services specified in the discharge/transition plan and ensure that transitional care occurs with minimal service disruption and with continuance of current Provider(s) when possible.
41. Assist in securing placement and ensure the setting to which the Member is transitioning is ready for the Member’s arrival.
42. Conduct follow up with the Member and Member’s Providers within forty-eight (48) hours of discharge to ensure post discharge services have been provided.
43. When a CONTRACTOR(S) is contacted by an inpatient facility for the CONTRACTOR(S) Member with a request for assistance with discharge planning, the CONTRACTOR(S) must initiate and implement the adequate steps described above to ensure discharge planning occurs for the Member.
44. As appropriate, depending on the details of the Member’s transition, the CONTRACTOR(S) shall ensure that the Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for a period of time even if that Provider is not in the CONTRACTOR(S)’ Provider network.
45. The CONTRACTOR(S) shall ensure the Member’s new Provider(s) is able to obtain copies of the Member’s medical records, as appropriate, in a manner that is compliant with Federal and State laws.
46. For transfers between CONTRACTOR(S), the CONTRACTOR(S) shall:
47. Both receiving and releasing, CONTRACTOR(S) must designate a single point of contact and provide contact information to the Member to aide in CONTRACTOR‑to-CONTRACTOR outreach during these transitions.
48. Receiving CONTRACTOR(S) must make outreach to the previous CONTRACTOR(S) to gather Member Provider information and PCSP or Plan of Service, as necessary.
49. Receiving CONTRACTOR(S) must utilize previous CONTRACTOR(S) Encounter Data provided by the State to determine previously utilized Member Providers and services.
50. Receiving CONTRACTOR(S) must develop or attempt to develop contracts with previously utilized Providers to ensure the continuity of care for Members.
51. Receiving CONTRACTOR(S) must update all pertinent documentation and planning to most effectively support the Member post-transition.
52. For transfers from FFS to CONTRACTOR(S), the CONTRACTOR(S) shall:
53. Utilize FFS Encounter Data provided by the State to determine the Member’s previously utilized services and Providers.
54. Execute or attempt to execute Provider agreements with previously utilized Providers to ensure continuity of care for Members.

CONTRACTOR(S) must make efforts to preserve existing relationships between Providers and Members in which the Provider was a main source of Medicaid services for the Member during the previous year.

1. As appropriate, the receiving CONTRACTOR(S) must request copies of all relevant PCSPs or Plans of Service, data, and health records.
2. Update all pertinent documentation and planning to most effectively support the Member post transition.
3. Additionally, Members may leave a CONTRACTOR’S assignment for the following reasons:
4. Member loses eligibility.
5. Member is placed in an adult or juvenile correctional facility.
6. Member selects another CONTRACTOR(S) during their Annual Open Enrollment period.
7. Member passes away.
8. Member transfers to a Medicaid eligibility category outside of managed care.
9. To implement the decision of a hearing officer in a formal grievance procedure by the Member against the CONTRACTOR(S) or by the CONTRACTOR(S) against the Member.
10. For Members leaving a CONTRACTOR(S)’ enrollment, the CONTRACTOR(S) shall ensure that any sharing of Member information is conducted with the consent of the Member or designated representative and in accordance with State and Federal privacy requirements. With consent the CONTRACTOR(S) shall ensure continuity of care by:
11. Referring the Member to the KanCare Enrollment Center to process the Member’s disenrollment.
12. Transferring relevant Member information, including medical records and other pertinent materials, when a Member is assigned to another CONTRACTOR(S).
13. Transferring relevant Member information, including medical records and other pertinent materials, when a Member transitions out of KanCare and into another State-administered setting (e.g. incarceration, State hospital, etc.).
14. Making relevant Member information, including medical records and other pertinent materials, available to the Member upon request.
15. Upon request, the CONTRACTOR(S) may be required to submit the transition of care strategy as prescribed by the State for approval.

### Conflicts of IntErest

For individuals enrolled in an HCBS Waiver, CONTRACTOR(S) shall not delegate or Subcontract the completion of the needs assessments or the development of the PCSP or Plan of Service to any entity that is also a Provider of services or conducts components of the eligibility process to that individual, unless it can be demonstrated that the only willing and qualified entity to perform independent assessments and development of PCSPs in a geographic area is also a direct service Provider as described in 42 CFR § 431.301(c)(1)(vi) and 441.730(b). Prior to contracting with such an entity, the CONTRACTOR(S) shall document that rigorous attempts were made to contract with a conflict‑free community-based organization. THE CONTRACTOR(S) shall seek permission from the State before contracting with the entity. The CONTRACTOR(S) must work with the entity to develop, review and approve conflict of interest protections as appropriate.

### Electronic Care Management System

1. The CONTRACTOR(S) must have an electronic Care Management System that captures at a minimum:
2. The results of the needs assessment.
3. The PCSP or Plan of Service content, including goals, interventions, progress, Outcomes, and completion dates.
4. Service coordinator Member touch points and Outcomes.
5. Members of the Care Management team who use the Care Management system must also have access to relevant electronic data about the Member (claims, PA data, admission discharge transfer (ADT) feeds) in order to coordinate and communicate care needs across Providers and delivery systems. Describe how the CONTRACTOR(S) intends to ensure real-time access to electronic data for the Service Coordinators.
6. In order to maximize internal CONTRACTOR(S) communications (e.g., the UM reviewer is able to see the Care Management risk level and the name of a care manager for a Member) about a specific Member the CONTRACTOR(S) must use information technology systems and processes to integrate the following data elements:
7. Enrollment data
8. Care management data
9. Claims and Member services
10. 24/7 nurse advice line information
11. PA data, etc.
12. The CONTRACTOR(S)’ system must also have the capability to make service management data available to the Member, the PCP, and specialists, as well as interface with the State’s Kansas Modular Medicaid System or in the format and method specified by the State.

### Service Coordination Reporting and Evaluation

1. The CONTRACTOR(S) shall have a system for monitoring and evaluating its Service Coordination model and shall include in their model of care description:
2. How they monitor Service Coordination.
3. The mechanisms by which they make process improvements.
4. How they evaluate Members’ satisfaction with Service Coordination, including but not limited to, LTSS and Behavioral Health services.
5. The CONTRACTOR(S) shall report on Service Coordination measures as described in the State’s KanCare Quality Strategy.
6. The CONTRACTOR(S) shall submit to the State Service Coordination reports in accordance with Attachment H of this RFP. The CONTRACTOR(S) shall comply with any additional requests from the State for Service Coordination reporting in the manner and timeframe prescribed by the State, this includes any one-time ad hoc reporting requests.
7. The CONTRACTOR(S) shall make all Service Coordination data, inclusive of Social Determinants of Health and Independence, including that which is generated by Subcontractors, available to the State upon request.
8. The CONTRACTOR(S) shall provide the following data elements in accordance with a schedule prescribed by the State to the State’s Electronic Visit Verification (EVV) vendor: scheduled times for service delivery, names of CONTRACTOR(S)’ service coordinators and their associated caseloads and names of contracted community service coordinators and their associated caseloads for purposes of State monitoring of compliance with contact schedules. In addition, the State may make changes for compliance with the 21st Century CURES Act in the near future. The CONTRACTOR(S) must provide all new data elements to comply with these changes.
9. The CONTRACTOR(S) shall comply with any requests for data from the State’s contracted External Quality Review Organization (EQRO).

### Service Coordination Collaborative

1. The CONTRACTOR(S) shall participate in a State-chaired KanCare Service Coordination collaborative. The purpose of the collaborative is to:
2. Address questions and issues the CONTRACTOR(S) Encounter in implementing the Service Coordination program.
3. Ensure the KanCare Service Coordination program is being implemented consistently throughout the State.
4. Share Service Coordination best practices and resources.

## Provider Network

### Credentialing and Re-Credentialing

Throughout the life of this CONTRACT, CONTRACTOR(S) shall assess their credentialing/re-credentialing processes, obtain Provider input on related practices, and take steps to improve, simplify, and streamline the processes whenever feasible. CONTRACTOR(S) shall provide an annual update to KDHE-DHCF describing the assessment conducted, input received, and modifications they have undertaken to make improvements implemented in the credentialing/re-credentialing of Providers.

The CONTRACTOR(S) shall:

1. Utilize the State Provider enrollment system to access all necessary applications and associated documentation, as it will be the system of record and is intended to maximize standardization of documentation and minimize repetitive effort on the part of the Providers.
2. Develop written policies and procedures for identification, recruitment, and retention of Participating Providers to include the establishment and implementation of a uniform credentialing and re-credentialing policy that addresses acute, primary, Behavioral Health and LTSS Providers and meets all applicable State and CMS (42 CFR § 438.214) requirements and comply with the HCBS Settings Rule (42 CFR § 441.301(c)(4)).
3. Follow a documented process for credentialing and re-credentialing of Providers who have signed contracts or participation agreements with CONTRACTOR(S) and use the Kansas Standardized Credentialing forms. CONTRACTOR(S) shall interface with the current standardized Provider enrollment system until such time that the automated Provider enrollment system is fully implemented by the State.
4. Demonstrate that its Providers are credentialed and reviewed through the CONTRACTOR(S)’ Credentialing Committee that is chaired by the CONTRACTOR(S)’ local Medical Director.
5. Comply with State requirements and document provisional credentialing, initial credentialing, re-credentialing, and organizational credential verification of Providers who have signed contracts or participation agreements with the CONTRACTOR(S) or have seen twenty-five (25) or more of the CONTRACTOR(S)’ Members.
6. CONTRACTOR(S) are required to credential and re-credential HCBS Providers consistent with applicable Waiver Provider qualification requirements and credentialing standards identified by the State for HCBS Providers and verify HCBS Provider compliance with Federal settings requirements at 42 CFR § 441.301(c)(4). The CONTRACTOR(S) shall extend consultation and support to its Participating Providers and any Subcontractors to demonstrate compliance with the home- and community-based settings criteria by March 17, 2022 for settings in which the criteria applies. The CONTRACTOR(S) shall identify a process for achieving compliance with the Federal HCBS Settings requirements as follows:
7. In the plan of care process, including expectations pertaining to employment and community integration.
8. In verifying Provider compliance with the Rule when credentialing and re-credentialing HCBS Providers.
9. In its CONTRACTOR(S)’ Provider Agreements by including language requiring Providers to maintain compliance with the Rule.
10. In furnishing Provider education and training on the Rule to establish and maintain ongoing compliance.
11. Ensure 1915(c) Provider qualifications are met both initially and ongoing.
12. Ensure that the credentialing process provides for re-credentialing to occur every three (3) years. Atypical Participating Providers (e.g., Providers of transportation, home and vehicle modifications, respite services) are not assigned a National Provider Identifier (NPI) number but shall be subjected to all applicable credentialing and re-credentialing requirements as outlined in this section.
13. Licensure and qualifications for all Participating Providers shall be verified initially and on an ongoing basis. CONTRACTOR(S) shall submit a plan to the State ninety (90) days before the start of the CONTRACT year that specifies the process for how Participating Provider licensure will be verified for all Provider types on an ongoing basis and the timelines for notification to the State when issues with Provider licensure and/or qualifications are identified.
14. Credentialing Timeframes: The CONTRACTOR(S) shall ensure that credentialing of all service Providers applying for Participating Provider status shall be completed within sixty (60) calendar days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the Provider notifying them of the CONTRACTOR(S)’ decision. Credentialed Providers must be entered/loaded into the CONTRACTOR(S)’ claims payment system within thirty (30) calendar days of Credentialing Committee approval.
15. Provider selection requirements must comply with 42 CFR § 438.12. CONTRACTOR(S)’ Provider selection policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. CONTRACTOR(S) may not employ or contract with Providers excluded from participation in Federal health care programs. CONTRACTOR(S) must timely notify Providers in writing of the reason for its decision if the CONTRACTOR(S) declines to include individuals or groups of Providers in its network.
16. The State may decide to contract with or require the CONTRACTOR(S) to contract with a single credentialing verification organization (CVO) to standardize Provider credentialing and re-credentialing processes across the KanCare program. The CONTRACTOR(S) shall work with the State on implementing any new processes related to centralized credentialing. Describe the CONTRACTOR(S)’ experience, if any, working with a credentialing verification organization in other state Medicaid programs.
17. CONTRACTOR(S) should encourage its opioid prescribing Providers to register in the Kansas Prescription Drug Monitoring Program, known as K-TRACS.

### Network Development

The CONTRACTOR(S) shall develop, maintain, and monitor a network of Providers that:

1. Is supported by written agreements and is sufficient in size, scope, and types to deliver all medically necessary Covered Services and satisfy all service delivery requirements in this CONTRACT.
2. Delivers culturally and linguistically appropriate services as described in Section 5.5.4, including in home- and community-based settings for culturally diverse populations.
3. Offers Members a choice of Providers to the extent possible and appropriate.
4. Ensures Covered Services are as accessible to Members in terms of timeliness, amount, duration, and scope as those services that are available to non-Medicaid persons within the same service area.
5. Ensures Covered Services are provided promptly and are reasonably accessible in terms of location and hours of operation.
6. Is designed, established and maintained by utilizing, at a minimum, the following considerations that promote the best interest and health and welfare of Members, including but not limited to:
7. Current and anticipated enrollment and utilization of services.
8. Cultural and linguistic needs of Members considering the prevalent languages spoken, including sign language.
9. Ability of Providers to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.
10. Each Participating Provider’s panel size (as applicable) including the number of Participating Providers not accepting new referrals. For those Participating Providers who are accepting new Members, the number of additional Members that the Provider is willing and able to accommodate.
11. Availability of triage lines or screening systems, as well as the use of telehealth (for example, Project ECHO), e-visits, and/or other technological solutions. The CONTRACTOR(S) should utilize telemedicine to support an adequate Provider network. Telemedicine shall not replace Provider choice and/or Member preference for physical delivery.
12. Geographically convenient flow of Members among Participating Providers to maximize Member choice.
13. Member satisfaction survey data and quality data (e.g., Healthcare Effectiveness Data and Information Set (HEDIS) performance).
14. Member Grievance and Appeal data.
15. Issues, concerns, and requests brought forth by State agencies and other system stakeholders that have involvement with persons eligible for services under this Contract.
16. Demographic data and geo-mapping data.
17. Support community integration for LTSS Members.
18. CONTRACTOR(S) shall adhere to the following requirements and considerations for specific Provider types within its Provider network:
19. Include Osawatomie and Larned State Hospitals.
20. Include a sufficient number of qualified Providers to timely meet the unique needs of children in the foster care system.
21. Include contracts with or otherwise support the Graduate Medical Education Residency Training Programs currently operating in the State, and to investigate opportunities for resident participation in CONTRACTOR(S) medical management and committee activities. The CONTRACTOR(S) must attempt to contract with graduating residents and Providers that are opening new practices in, or relocating to, Kansas, especially in rural and underserved areas.
22. Include at least one FQHC, RHC, and Free-Standing Birthing Center (FBC) in accordance with CMS’ State Health Officials Letter #16-006.
23. Include Providers that offer services to both children and adult Members moving from one system of care to another system of care in order to maintain continuity of care without service disruptions or mandatory changes in service Providers for those Members who wish to keep the same Provider in accordance with State policy.
24. Include a sufficient number of locally established, Kansas-based, independent peer/consumer and family operated/run organizations to provide support services, advocacy and training, including Consumer Run Organizations (CROs).
25. Ensure in-State Members receive services from in‑State Providers when available at competitive rates and levels of quality.
26. Ensure that an appropriate number of Behavioral Health and LTSS Providers exist to meet Member needs.
27. Contracts with any willing Pharmacy Provider that meets requirements to participate in the CONTRACTOR(S) network.
28. Develops incentive plans to recruit and retain Behavioral Health professionals and medical practitioners in the local community.
29. Includes specialty service Providers to deliver services to children, adolescents, and adults with developmental or cognitive disabilities, sexual offenders, sexual abuse victims, individuals with Behavioral Health disorders, individuals in need of dialectical behavior therapy, transitioned aged youth ages 18 to 21, and infants and toddlers under the age of five (5) years.
30. Implements e-prescribing within its Provider network.
31. Demonstrates that there are sufficient Indian Health Care Providers (IHCPs) participating in the CONTRACTOR(S)’ Provider network to ensure timely access to services available under this CONTRACT from such Providers for American Indian Members who are eligible to receive services.
32. Monitors open panels for LTSS services including HCBS.
33. Includes a proposal for a methodology to develop Direct Primary Care networks in Kansas. If the CONTRACTOR(S) has developed Direct Primary Care networks in other states, describe in detail the success or challenges of building networks in those states.
34. The CONTRACTOR(S) must submit documentation to the State, in an approved format and frequency as specified by the State, that demonstrates the Provider network offers an appropriate range of preventive, primary, Behavioral Health, specialty, LTSS, and Pharmacy services that is adequate for the anticipated number of Members and maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members. The CONTRACTOR(S) must submit the documentation no less frequently than the following:
35. At the time it enters into a CONTRACT with the State.
36. At any time there is a significant change (as defined by the State) in the CONTRACTOR(S)’ operation that would affect adequate capacity and services.
37. If there are changes in services, benefits, geographic service areas.
38. If a new population is enrolled.
39. The CONTRACTOR(S) shall quarterly report the number and types of Providers in their network consistent with the State’s reporting requirements.
40. The documentation of network adequacy shall be signed by the Chief Executive Officer (CEO) and submitted quarterly to the State.
41. The State may impose sanctions for material deficiencies in the CONTRACTOR(S)’ Provider network.

### Provider Network Adequacy Standards

1. The State is currently developing time and distance and other required network adequacy standards, including established timeframes to receive authorized LTSS and Behavioral Health services, for the Provider types specified in 42 CFR § 438.68. These Provider types include the following:
2. Primary care, adult and pediatric (pediatric standards apply to Members age  
   0–20)
3. OB/GYN
4. Behavioral Health (mental health and SUD), adult, and pediatric
5. Specialist, adult, and pediatric (pediatric standards apply to Members age 0–20)
6. Hospital
7. Pharmacy
8. Pediatric dental (pediatric standards apply to Members age 0–20).
9. Time and distance standards for LTSS Provider types in which a Member must travel to the Provider to receive services.
10. Network adequacy standards other than time and distance standards for LTSS Provider types that travel to the Member to deliver services or require the Member to move in order to receive services. Examples include, but are not limited to, timely initiation of services after the PCSP or Plan of Service signature, timely appointments and service delivery, Provider to enrollee ratios and other standards related to language, cultural competence, and physical accessibility.

For reference, CONTRACTOR(S) should refer to existing KanCare Geo Access standards available at <https://www.kancare.ks.gov/policies-and-reports/network-adequacy>. The final network adequacy framework for the January 1, 2019 CONTRACT year will also include an exceptions process for CONTRACTOR(S) to use in the event the CONTRACTOR(S)’ network cannot satisfy the network adequacy standard for a specific Provider type. The State must approve any exception to the CONTRACTOR(S)’ network adequacy standards.

### Cultural Competency and Health Literacy in the Delivery of Care

1. The CONTRACTOR(S) shall:
2. Promote and participate in the State’s efforts to ensure that Covered Services are delivered in a culturally competent manner to all Members and is responsive to Members’ health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Cultural competency refers to the practices and behaviors that ensure that all Members receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a Member’s characteristics.

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand back health information and services needed to make appropriate health decisions.

1. Adhere to requirements for establishing a Provider directory as specified in Section 5.10.8 that indicates each Provider’s linguistic capabilities, as well as whether the Provider has completed cultural competence training, and whether the Provider’s offices, exam rooms, and equipment accommodate individuals with physical disabilities.
2. Ensure that Members are provided Covered Services without regard to race, color, national origin, sex, sexual orientation, gender identity, age, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, age, or disability.
3. Incorporate in its policies, administration, and service practice the values of (i) honoring Member’s beliefs, (ii) sensitivity to cultural diversity, and (iii) fostering in staff and Providers’ attitudes and interpersonal communication styles which respect Members’ cultural backgrounds. The CONTRACTOR(S) shall have specific policy statements on these topics and communicate them to Subcontractors and Participating Providers.
4. Foster and enhance Participating Providers’ understanding and application of techniques to identify and adapt to Members’ cultural preferences and health literacy needs as an integrated component of service delivery. Such supports should include interactive and ongoing training, dedicated CONTRACTOR(S)’ staff for Participating Providers to consult as needed, a resource library of best practices and national standards, and other resources as appropriate to evidence the importance of cultural competency and health literacy in the delivery of Covered Services.
5. Permit Members to choose any Participating Provider from among the CONTRACTOR(S)’ network based on cultural preference. Members may submit grievances to the CONTRACTOR(S) and/or the State related to inability to obtain culturally appropriate care.
6. If the CONTRACTOR(S) identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its Subcontractors or Participating Providers, it shall promptly intervene and require a Corrective Action Plan from the Subcontractor or Participating Provider. Failure to take prompt corrective measures may place the CONTRACTOR(S) in default of its CONTRACT.
7. Cultural Competency Plan: Within 90 days of award, the CONTRACTOR(S) shall develop and submit for State approval a Cultural Competency Plan. The Cultural Competency Plan shall be evaluated, updated, and submitted annually to the State. The Cultural Competency Plan shall include, but not be limited to:
8. Description of how care and services are delivered in a culturally competent manner, including how this will be achieved in rural areas of the State via telehealth strategies.
9. Role of Social Determinants of Health and Independence in improving and sustaining positive health Outcomes.
10. Strategies to assess and respond to the health literacy needs of Members
11. Identification of the CONTRACTOR(S)’ specific staff responsible for the development and maintenance of the Cultural Competency Plan.
12. Goals for the coming year.
13. Training and education methods utilized by the CONTRACTOR(S) to educate staff, Participating Providers, and Members about cultural competency, including a description of the training programs.
14. Description of how the CONTRACTOR(S) conducts regular assessments of the Provider network to ensure services are provided in a culturally competent manner to diverse populations.

### Provider Network Access Standards

The CONTRACTOR(S) shall maintain a Provider network that can satisfy the following timely access standards to Covered Services.

#### General Standards

CONTRACTOR(S) must adhere to the following requirements:

1. Responds to referrals twenty-four (24) hours per day seven (7) days per week and provides access to evening and weekend appointments.
2. Responds to routine, urgent, and emergent needs within the established timeframes in conformance with State requirements.
3. Appointment times shall be in accordance with usual and customary standards not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for Urgent Care.
4. Waiting times shall not exceed forty-five (45) minutes.

#### Primary Care Provider Standards

CONTRACTOR(S) must adhere to the following requirements:

1. Make available non-emergent after-hours physician services or Primary Care services
2. Encourage the assignment of pediatricians to serve as PCPs for eligible children
3. Offer Members freedom of choice within its network in selecting a PCP consistent with this CONTRACT
4. Give Members a choice of at least two (2) PCPs. The CONTRACTOR(S) shall not restrict PCP choice unless a Member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. In addition, the CONTRACTOR(S) shall offer contracts to primary and specialist physicians who have established relationships with Members including specialists who may also serve as PCPs to encourage continuity of Provider.
5. Ensure individuals who transition to the CONTRACTOR(S) for their physical health from another CONTRACTOR(S) and who have an established relationship with a PCP that does not participate in the CONTRACTOR(S)’ Provider network, the CONTRACTOR(S) will provide, at a minimum, a six (6)-month transition period in which the individual may continue to seek care from their established PCP while the individual and the CONTRACTOR(S) finds an alternative PCP within the CONTRACTOR(S)’ Provider network.
6. Offer pregnant Members a choice to be assigned a PCP that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member’s continuity of care.
7. Permit any American Indian Member eligible to receive services from an IHCP PCP participating as a Participating Provider, to choose that IHCP as his or her PCP, as long as that Provider has capacity to provide the services.

#### Specialty Care Standards

CONTRACTOR(S) must adhere to the following requirements:

1. Specialty Care and Urgent Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.
2. Waiting times shall not exceed forty-five (45) minutes.

#### Emergency Care Standards

CONTRACTOR(S) must adhere to the following requirements:

1. Emergency Care: All emergency care is immediate, at the nearest facility available, regardless of whether the Emergency Room (ER) is a Participating Provider.
2. Emergency services must be available twenty-four (24) hours a day, seven (7) days a week.

#### Non-Emergency Medical Transportation Service Standards

CONTRACTOR(S) shall adhere to the following requirements:

1. A Member’s transportation for physical, Behavioral Health, and LTSS services shall arrive at the Provider location:
   1. No sooner than one (1) hour before the Member’s appointment.
   2. At least fifteen (15) minutes prior to the Member’s appointment time.
2. The Member shall not wait for more than one (1) hour after the appointment for return transportation.
3. Non-Emergency Medical Transportation Providers shall communicate with the Member regarding the approximate arrival time and shall promptly notify the Member when the transportation Provider will arrive later than the scheduled pick‑up time.
4. When returning the Member to the point of origin, Non-Emergency Medical Transportation Providers shall ensure return routes are efficient, do not result in unnecessary delays, and do not include scheduled or unscheduled stops during the return trip.
5. CONTRACTOR(S) must develop and implement a quarterly performance auditing protocol to evaluate compliance with these standards for subcontracted Non-Emergency Medical Transportation Providers.
6. CONTRACTOR(S) must ensure that an exception process is in place to accommodate Members who require same day Non-Emergency Medical Transportation services in order to access any medically necessary Covered Service(s) under the CONTRACT.
7. CONTRACTOR(S) must submit to the State for approval any PA requirements for mileage, lodging, and meal reimbursement.

### Long-Term Services and Supports Provider Network Standards

The CONTRACTOR(S) shall develop, maintain, and monitor a Provider network, including HCBS Providers and alternative residential settings (e.g. Assisted Living Facilities, Home Plus, Residential Health Care Facilities, and IDD Day and Residential settings) that are supported by written agreements, which is sufficient to provide all LTSS Covered Services. The CONTRACTOR(S) shall:

1. Comply with State-established Provider network standards, including, but not limited to, time and distance standards for applicable Provider types covered under the CONTRACT, including time and distance standards for LTSS Provider types in which a Member must travel to the Provider to receive services and network adequacy standards for LTSS Provider types that travel to the Member to deliver services and Providers that require the member to move in order to receive services.
2. Comply with additional network adequacy metrics specific to LTSS population, as identified by the State, to demonstrate timely initiation of service and ongoing service as compared to the Members’ schedule for services.
3. Place a priority on allowing Members, when appropriate, to reside or return to their own home vs. having to reside in an institutional or alternative residential setting.
4. Promote person-centered care through the development of services and settings that support the mutually agreed upon PCSP or Plan of Service through all service settings.
5. Develop HCBS and settings to meet the needs of Members who have cognitive impairments, Behavioral Health needs, and other special medical needs and comply with HCBS setting requirements.
6. CONTRACTOR(S) shall directly contract with an adequate network of Kansas-based FMS Providers to offer choice for Members. For Members self‑directing their services and using a FMS Provider to assist in processing claims and payments to their direct support workers, CONTRACTOR(S) shall reimburse FMS Providers separately for administrative functions and direct service workers funds.
7. Ensure that all licensed and Medicaid-certified NFs will be offered inclusion in the CONTRACTOR(S) Provider network. The CONTRACTOR(S) can evaluate each Provider’s continued network enrollment based on the assessment of quality and performance Outcomes. A CONTRACTOR(S) shall request approval from the State if it wants to terminate the CONTRACT of a NF for poor quality of care and not meeting performance Outcomes. The CONTRACTOR(S) must, in their request to the State, indicate the reasons for the termination, remedial actions that have been taken, preliminary plan on where residents would be transferred, impact of the transfers on the NF, and local community, and any other information that the CONTRACTOR(S) believe is relevant. Provider network agreements shall only be with NFs certified under Medicaid but CONTRACTOR(S) will be expected to help NFs move to both Medicare and Medicaid certification to maximize use of Medicare funding.

### Behavioral Health Provider Network Standards

The CONTRACTOR(S) shall adhere to the following requirements:

1. The CONTRACTOR(S) will retain and recruit a sufficient number of Behavioral Health Providers to maintain network adequacy as defined for the applicable urban, rural, and frontier counties in the service area. The CONTRACTOR(S) shall respond to any State requests or inquiries relative to the adequacy of its Behavioral Health Provider network.
2. The availability of types of Behavioral Health programs will vary from area to area, but access problems may be especially acute in rural and frontier areas. The CONTRACTOR(S) shall establish a program of assertive outreach and telemedicine programming capabilities to all areas but especially to rural and frontier areas where Behavioral Health services may be less available than in more urban areas. The CONTRACTOR(S) shall monitor utilization in regions across the State to ensure access and availability of all Behavioral Health services in all regions.
3. The CONTRACTOR(S) shall document, and make available upon request, waiting lists preventing Admission to treatment in the prescribed timeframes.
4. For Members presenting for SUD services:
5. The CONTRACTOR(S) may limit the number of SUD Providers in the network open panel to those needed to provide adequate Provider network coverage and services.
6. For emergency needs, Members shall be referred to services immediately.
7. Members with urgent, non-emergency needs shall be assessed within twenty‑four (24) hours of a request for services. Services shall be delivered within twenty-four (24) hours of the date and time of the assessment.
8. Members with non-urgent needs shall be assessed within fourteen (14) calendar days of the date the services are requested.
9. Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within twenty-four (24) hours of assessment. When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care.
10. Persons who inject drugs must receive an assessment and shall be admitted to treatment no later than fourteen (14) calendar days after making the request for assessment. If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment.
11. For Members presenting for mental health services:
12. For emergency needs Members shall be referred to services immediately.
13. Members with urgent, non-emergency needs shall be assessed within seventy‑two (72) hours of a request for services.
14. Members with non-urgent needs shall be assessed within fourteen (14) business days of the date the services are requested.
15. The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include:

Crisis responsiveness which includes twenty (24) hours a day, seven (7) days a week, 365 days a year emergency treatment and first response, including, when appropriate, staff going to the Member for personal intervention and for any Member that staff become aware of experiencing a crisis or other emergency.

Provision of or referral to psychiatric and other community services, when appropriate.

Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services.

Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services.

Follow up with any Member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.

1. In cases of discharge from inpatient care, the CONTRACTOR(S) will monitor Provider contact with the Member following inpatient discharge with goals of offering and encouraging Member’s attendance at follow-up appointments. The timeframe begins with the day of the Member’s discharge. The CONTRACTOR(S) will ensure 85% of contact attempts will occur between twenty-four (24) to seventy-two (72) hours of discharge; 90% of contact attempts will occur within 1–7 days; and 95% of contact attempts will occur within 1–10 days. The CONTRACTOR(S) will have protocols in place to review for compliance with this CONTRACT requirement.

### Network Management

The CONTRACTOR(S) shall:

1. Establish procedures to ensure that network Providers comply with all timely access requirements as defined by the State and specified in Section 5.5.5, 5,5,6 and 5.5.7, and provide documentation demonstrating monitoring efforts. As network access issues arise, the CONTRACTOR(S) shall report areas of network deficiency within twenty-four (24) hours and a plan for resolution to the State within five (5) business days. Report must be made to the State Medicaid Agency and the State Operating Agency as applicable.
2. Monitor Providers to demonstrate compliance with all network requirements in this Contract including, at a minimum, the following:
3. Technical assistance and support to consumer and family-run organizations.
4. Distance traveled, location, time scheduled, and Member’s response to an offered appointment for services.
5. Status of required Provider licenses, registration, certification, or accreditation.
6. Eliminate barriers that prohibit or restrict advocacy for the following:
7. The Member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.
8. Any information the Member needs in order to decide among all relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment.
9. The Member’s right to participate in health care decisions including the right to refuse treatment and to express preferences about future treatment decisions.
10. Continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, Member grievances and appeals, quality data, quality improvement data, eligibility, utilization of services, penetration rates, Member satisfaction surveys, and demographic data requirements.
11. When feasible, develop non-financial incentive programs to increase participation in CONTRACTOR(S)’ Provider network.
12. The CONTRACTOR(S) shall permit Members to change Providers at any time and for any reason except as specified in Section 5.8.3.5.
13. The CONTRACTOR(S) shall conduct ongoing network management activities. The activities shall include, but not be limited to:
14. Developing a process and timeline for Provider-specific profile reports. Profile reports shall include a multi-dimensional assessment of each Provider’s performance using indicators for performance that address, at a minimum, clinical quality, access, UM, and Member satisfaction. The indicators selected shall be clinically relevant, quantitatively measurable, and appropriate to the population. The CONTRACTOR(S) shall submit a copy of its Provider profile report template to the State prior to distribution to the Provider network.

### Non-Participating Providers

The CONTRACTOR(S) shall:

1. Provide adequate, timely, and medically necessary Covered Services through a Non‑Participating Provider if the CONTRACTOR(S)’ network is unable to provide adequate and timely services required under this Contract and continue to provide services by a Non-Participating Provider until a Participating Provider is available.
2. Provide documentation to the State on a quarterly basis describing the need to rely on Non-Participating Providers for the delivery of Covered Services for each Non‑Participating Provider claim paid.
3. Coordinate with Non-Participating Providers for authorization and payment.
4. The State expects Non-Participating Providers to use the CONTRACTOR(S)’ grievance, reconsideration, Appeal, and State Fair Hearing process to address disputes with a CONTRACTOR(S) as stated in Attachment D and the Kansas Statutes Annotated (K.S.A.) 77-501 et seq.
5. If the State determines that any CONTRACTOR(S) has a pattern of inappropriately denying payments to Non-Participating Providers, the CONTRACTOR(S) may be subject to suspension of new enrollments, withholding of capitation payments, CONTRACT termination, or refusal to CONTRACT in a future time period. This applies to cases where the State has ordered payment after Appeal and also to cases where no Appeal has been made (i.e., the State is knowledgeable about abuse from other sources).
6. Negotiate and execute written single-case agreements or arrangements with Non‑Participating Providers, when necessary, to ensure access to Covered Services.
7. Ensure that no Provider bills a Member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing, spenddown, client liability and client obligations, and non-Title-XIX sliding fee scale payments by Members. The CONTRACTOR(S) shall ensure that cost to the Member is no greater than it would be if services were provided by a Participating Provider.
8. Prior to paying claims to a Non-Participating Provider that is not enrolled with Kansas Medical Assistance Program (KMAP), the CONTRACTOR(S) will, at a minimum, verify licensure and perform all Federal database checks as specified in 42 CFR § 455.436 on all Owners and managing employees.
9. Arrange for the service to be provided outside the network, if a qualified Provider is available, if a Member needs a specialized, medically-necessary Covered Service that is not available through the network.
10. The CONTRACTOR(S) must permit American Indian Members to obtain Covered Services under this Contract from non-participating IHCPs from whom the Member is otherwise eligible to receive such services.
11. The CONTRACTOR(S) must permit a non-participating IHCP to refer an American Indian Member to a Participating Provider.
12. Ensure that the CONTRACTOR(S)’ Provider network adheres to the following:
13. Provides female Members with direct access to a women's health specialist within the Provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member’s designated source of Primary Care if that source is not a women's health specialist.
14. Provides for a second option from a Participating Provider, or arranges for the Member to obtain one outside the network at no cost to the Member.
15. Demonstrates that its network includes sufficient family planning Providers to ensure timely access to Covered Services.

### Material Change to Provider Network

A material change to the Provider network is defined as one that affects, or can reasonably be foreseen to affect, the CONTRACTOR(S)’ ability to meet performance and/or Provider network standards as described in this CONTRACT, including, but not limited to, any change that would cause or is likely to cause more than 5% of Members in a service area to change the location where services are received or rendered.

1. The CONTRACTOR(S) is responsible for evaluating all Provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the CONTRACTOR(S)’ Provider network.
2. All material changes to the Provider network must be approved in advance by the State.
3. The CONTRACTOR(S) must submit the request for approval of a material change to the Provider network along with a description of how the change will affect the delivery of Covered Services, the CONTRACTOR(S)’ plans for maintaining the quality of Member care, and communications to Providers and Members. The CONTRACTOR(S) must submit the request for approval within fourteen (14) calendar days of identifying a material change.
4. A material change in the CONTRACTOR(S)’ Provider network requires thirty (30) days advance written notice from the CONTRACTOR(S) to Members and Providers. In the event unforeseen circumstances prevent the CONTRACTOR(S) from providing 30 days advance written notice to Members and Providers, the CONTRACTOR(S) shall notify the State within one (1) business day of identifying the material change to the Provider network for the State’s determination of notification requirements.

### Provider-Member Communication

The CONTRACTOR(S) may not prohibit, or otherwise restrict, a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

1. The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
2. Any information the Member needs to decide among all relevant treatment options.
3. The risks, benefits, and consequences of treatment or non-treatment.
4. The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

### Avoiding and Disclosing Potential Conflicts of Interest

1. Any CONTRACTOR(S) that engages or proposes to engage in a relationship(s) with any parties that have any legal, financial, contractual, or related party interests with a Provider or group of Providers to be reimbursed through the State shall demonstrate both an organizational structure and policies and procedures that would prevent the opportunity for, or an actual practice which allows, a situation in which the CONTRACTOR(S) gains any financial benefit from any policy or practice related to network recruitment, referral, reimbursement, service authorization, monitoring and oversight, or any other practice which might bring financial gain.
2. The CONTRACTOR(S) and any Subcontractors shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of KDHE‑DHCF or the State without written approval by KDHE-DHCF. Any such work that involves LTSS or Behavioral Health Providers will also need written approval from KDADS.
3. Specific situations that may be indicative of a conflict of interest include, but are not limited to, the following:
4. A change of the distribution of referrals or reimbursement among Providers within a level of care.
5. Referral by the CONTRACTOR(S) to only those Providers with whom the CONTRACTOR(S) shares an organizational relationship.
6. Preferential financial arrangements by the CONTRACTOR(S) with those Providers with whom the CONTRACTOR(S) shares an organizational relationship.
7. Different requirements for credentialing, privileging, profiling, or other network management strategies for those Providers with whom the CONTRACTOR(S) shares an organizational relationship.
8. Substantiated complaints by Members of limitations on their access to Participating Providers of their choice within an appropriate level of care.
9. The CONTRACTOR(S) shall fully and completely disclose any situation that may present as a conflict of interest.
10. If the CONTRACTOR(S) is now performing or elects to perform during the term of this CONTRACT any services for any CONTRACTOR(S), Provider or an entity owning or controlling the same, the CONTRACTOR(S) shall disclose this relationship prior to accepting any assignment involving such party.
11. Should a conflict of interest and/or preferential treatment be determined by the State at any time during the CONTRACT period, the State reserves the right to sanction the CONTRACTOR(S) or take other actions up to and including recoupment of CONTRACTOR(S) payments and terminating the Provider from the CONTRACTOR(S)’ Provider network.

### Delegation Relationships

The requirements of this section apply to any contract or written arrangement that the CONTRACTOR(S) has with any Subcontractor. If any of the CONTRACTOR(S)’ activities or obligations under this CONTRACT are delegated to a Subcontractor, the CONTRACTOR(S) shall:

1. Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its CONTRACT with KDHE-DHCF.
2. Ensure the terms of Subcontracts are subject to the applicable material terms and conditions of the CONTRACT existing between the CONTRACTOR(S) and KDHE‑DHCF for the provision of Covered Services.
3. Evaluate a prospective Subcontractor’s ability to perform duties to be delegated.
4. Ensure that delegated activities or obligations and related reporting responsibilities are specified in the Subcontract and that the Subcontractor agrees to perform the delegated activities and reporting responsibilities as specified in compliance with the CONTRACTOR’S obligations under this CONTRACT. All Subcontracts must contain full disclosure of all terms and conditions, including disclosure of all financial or other requested information.
5. Monitor Subcontractors’ payments to Participating Providers to ensure Subcontractors are reimbursing Providers at no less than the FFS schedule. Subcontractors are to be compliant with changes to the fee schedule by the effective date of relevant fee schedules.
6. Monitor the Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by KDHE-DHCF. As a result of the performance review, any deficiencies must be communicated to the Subcontractor in order to establish a corrective action plan. The results of the performance review and the corrective action plan shall be communicated to KDHE-DHCF upon completion.
7. Inform KDHE-DHCF in writing if a Subcontractor is noncompliant to the extent it would affect its ability to perform the duties and responsibilities of the Subcontract.
8. Ensure that the Contract or other written arrangement either provides for revocation of the delegation activities or obligations, or specifies other remedies, including imposing liquidating damages, in instances where KDHE-DHCF or the CONTRACTOR(S) determine that the Subcontractor has not performed satisfactorily.
9. Ensure that information specified in 42 CFR § 438.10(g)(2)(xi) about the Grievance and Appeal System is provided to all Subcontractors at the time they enter into a Subcontract.
10. Be responsible for ensuring that its Subcontractors are notified when modifications are made to KDHE-DHCF requirements, policies, and manuals.
11. Not delegate or enter into a Subcontract or a comprehensive management services agreement to perform key operational functions that are critical for integrated health care service delivery, including, at a minimum:
12. Grievance and Appeal System
13. Quality Management
14. Medical Management
15. Provider Relations
16. Network and Provider Services Contracting and Oversight
17. Member Services
18. Corporate Compliance
19. Each Subcontract, and, upon the request of the State, any further delegations by a Subcontractor, shall be subject to review and/or written approval by the State

### Minimum Subcontract Provisions

1. If a CONTRACTOR(S) chooses to use Subcontractors, the State encourages the CONTRACTOR(S) to use Kansas Subcontractors, including small and emerging businesses or small entrepreneurships. All Subcontracts must reference and require compliance with KDHE-DHCF Minimum Subcontract Provisions. Each Subcontract must contain the following:
2. Identification of the name and address of the Subcontractor.
3. Identification of the population, to include Member capacity, to be covered by the Subcontractor.
4. The amount, duration, and scope of services to be provided and for which compensation will be paid. No assignment of delegation of the duties of the Subcontract shall be valid unless prior written approval is received from the CONTRACTOR(S).
5. Full disclosure of the method and amount of compensation to be received by the Subcontractor. No payment due to the Subcontractor under the Subcontract may be assigned without the prior approval of the CONTRACTOR(S).
6. The term of the Subcontract including beginning and ending dates, methods of extension, termination, and renegotiation.
7. Include written requirements that the Subcontractor agrees to comply with all applicable Medicaid laws, State laws, policies, and regulations, including applicable sub-regulatory guidance and CONTRACT provisions.
8. Include a requirement that any services described in the Provider agreement that directly serve the State of Kansas or its Members and involve access to secure or sensitive data or personal Member data shall be performed within the defined territories of the United States.
9. Require Subcontractors to adhere to the requirements regarding disclosure of Ownership and control and disclosure of information on persons convicted of crimes as outlined in 42 CFR § 438.610.
10. Include in subcontracts with Subcontractors that Participating Providers shall report all suspected Fraud, Waste, or Abuse to KDHE-DHCF regardless of funding source.
11. Include in subcontracts a statement that a merger, reorganization or change in Ownership of a Subcontractor of the CONTRACTOR(S) shall require a Contract amendment and prior approval of KDHE-DHCF.
12. The duties of the Subcontractor relating to coordination of benefits and determination of Third Party Liability (TPL), including requirements that the Subcontractor agree to identify Medicare and other TPL coverage and to seek Medicare or TPL payment before submitting claims to the CONTRACTOR.
13. A description of the Subcontractor’s patient, medical, and cost record keeping system, including assurances that the Subcontractor shall safeguard confidential information in accordance with Federal and State laws, regulations, policies, and HIPPA.
14. Include requirements that the Subcontractor must retain, as applicable, Member Grievance and Appeal records, base data and audited financial reports, and data requested to support the CONTRACTOR(S)’ Medical Loss Ratio (MLR) reporting requirements.
15. A written expectation that requires compliance with KDHE-DHCF and the CONTRACTOR(S)’ quality management programs, medical management programs, and shall comply with the utilization control and review procedures in conformance with CMS rules and regulations and the KDHE-DHCF Quality Strategy.
16. A provision that states KDHE-DHCF is responsible for enrollment, re-enrollment and disenrollment of the covered population.
17. A requirement that the Subcontractor must comply with Encounter reporting and claims submission requirements as applicable to the CONTRACTOR(S).
18. Include written requirements that the Subcontractor develop and follow written policies and procedures for the processing of requests for initial and continuing authorization of services.
19. A statement that compensation to individuals or entities that conduct UM and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.
20. A requirement that the Subcontractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.
21. A provision that requires the Subcontractor to assist Members in understanding their right to file grievances and appeals in conformance with all KDHE-DHCF Grievance and Appeal System and Member rights policies.
22. A provision that details remediation activities if the Subcontractor fails to comply with subcontract requirements, including but not limited to, corrective action plans, sanctions and penalties, and subcontract termination.
23. Include written requirements that the Subcontractor agrees that the State, CMS, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the Subcontractor or the Subcontractor’s CONTRACTOR(S) that pertain to any aspect of services and amounts payable under the CONTRACTOR(S)’ CONTRACT with KDHE-DHCF. For purposes of an audit, evaluation, or inspection, the Subcontractor shall make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Members at no cost.
24. Written requirements that allow the CONTRACTOR(S) to suspend, deny, refuse to renew, or terminate any Subcontractor in accordance with the terms of this RFP/Contract and applicable law and regulation.
25. Require management services Subcontractors to prepare a Business Continuity and Recovery Plan within ninety (90) days of CONTRACT award.
26. Maintain a fully executed original or electronic copy of all Subcontracts, which shall be accessible to KDHE-DHCF within five (5) business days of request.
27. For all Subcontracts at least annually, the CONTRACTOR(S) shall provide to the State a monitoring plan for assessing and ensuring high quality Subcontractor performance.
28. Whenever any CONTRACTOR(S) has a change in any material Subcontractor, the CONTRACTOR(S) shall assign a project manager who is familiar with effective project management techniques and tools, and shall develop and submit to the State a project plan to guide the transition to a new Subcontractor, and shall include regular reporting to the State of key timeline, milestones, accomplishments, risks, and mitigation plans associated with the transition. Examples of material Subcontractors may include but are not limited to dental, vision, transportation, Pharmacy, or Behavioral Health vendors. Subcontractors fulfilling purely administrative functions shall be excluded from this requirement.

### Provider Payment

1. Special Terms Regarding Provider Payments
2. Minimum Reimbursement to Participating Providers: For Participating Providers, the published Medicaid FFS rate shall be the rate that would be received in the FFS Medicaid program inclusive of options for quality and Outcomes incentive payments. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the “Medicaid FFS rate”. The State will notify CONTRACTOR(S) of updates to the Medicaid fee schedule and payment rates.
3. The Provider may enter into alternative reimbursement arrangements with the CONTRACTOR(S) if the Provider initiates the request and it is approved in advance by the State including the Operating Agency for LTSS and Behavioral Health services arrangements.
4. For Behavioral Health and LTSS, the CONTRACTOR(S) shall utilize the established Medicaid FFS rate as the floor for payment to applicable Participating Providers.
5. For the State Hospitals, the CONTRACTOR(S) shall reimburse the Providers for 100% of costs based on the State’s established payment process and methodology. CONTRACTOR(S) will comply with state on payment adjustments to ensure that 100% of costs are covered.
6. FQHC/RHC/Critical Access Hospitals (CAH) Reimbursement:
7. The CONTRACTOR(S) shall not enter into alternative reimbursement arrangements with FQHCs, RHCs, or CAHs without prior approval from the State.
8. The CONTRACTOR(S) shall reimburse an FQHC and RHC the Prospective Payment System rate in effect on the date of service for each Encounter.
9. CAHs are reimbursed according to the diagnosis-related group fee schedule.
10. Inpatient hospitals and nursing facilities are entitled to three (3) reasonable offers at or above the FFS rates unless another payment structure is negotiated. If any Provider does not have a Provider agreement with the CONTRACTOR, non-Participating Providers will receive ninety percent (90%) of FFS rates. This payment requirement also applies to services provided under the Prudent Layperson definition of emergency services.
11. NF, Nursing Facility for Mental Health (NFMH), PRTF and ICF/IID rates: The State will establish FFS per diem rates for NFs, NFMHs, PRTFs, and ICF/IIDs utilizing a cost and acuity‑based methodology. The CONTRACTOR(S) will be required to pay, at a minimum, each facility the FFS rate as established by the State.
12. Kansas Medicaid NF, NFMH, PRTF, and ICF/IID FFS per diem rates are based on their historical costs subject to limits, and adjustments for the level of acuity of their residents. Each Kansas NF, NFMH, PRTF, and ICF/IID submits an annual cost report to the KDADS where it is reviewed for accuracy. Reimbursement rates for qualifying ventilator dependent residents are determined separately from the regular NF reimbursement methodology.
13. The CONTRACTOR(S) and Participating Provider can negotiate higher per diem rates without approval from the State for situations, including, but not limited to, dually-certified facilities, limited Provider access areas, and difficult or expensive cases. All alternative payment methodologies, including value-based payment arrangements with NFs, NFMHs, PRTFs, and ICF/IIDs must be reviewed and approved by the State pursuant to Section 5.7.
14. The CONTRACTOR(S) shall reimburse a NF 100% of the established FFS rate when a NF is sold and while the facility is being re-credentialed.
15. CONTRACTOR(S) shall ensure that Indian Health/Tribal/Urban Indian Health (I/T/U) Providers, whether participating in the network or not, be paid for covered Medicaid or CHIP KanCare services provided to American Indian Members who are eligible to receive services from such Providers either (i) at a rate negotiated between the CONTRACTOR(S) and the I/T/U Provider, or (ii) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the Provider were not an I/T/U Provider.
16. CONTRACTOR(S) must require Participating Providers to identify Provider Preventable Conditions as a condition of payment and comply with the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR § 434.6(a)(12) and 447.26. CONTRACTOR(S) must report all Provider preventable conditions in a form and frequency as specified by KDHE-DHCF.
17. CONTRACTOR(S) shall identify LTSS and Behavioral Health services Providers that are having significant billing problems and how it will work with the Providers in order to educate and train Providers to assist in resolving billing issues.

## Provider Services

The CONTRACTOR(S) shall:

1. Provide in-person and web-based training that has been approved by the State, for all Participating Providers, including Participating Providers that deliver HCBS Waiver services. The CONTRACTOR(S) shall offer the training to all Participating HCBS Providers at least on an annual basis. The content of this training shall include, but is not limited to, accountable quality care and the unique safety and Wellness issues associated with HCBS Waiver services. In addition, the training shall be tracked by the CONTRACTOR(S), to be reported on an annual basis or as requested by the State. This in-person training shall be conducted at various cities in the State, and will have at least one (1) HCBS and two (2) general Provider sessions per year. CONTRACTOR(S) shall notify the State within thirty (30) days of the scheduled training and ensure adequate space is available for State staff to attend.
2. Provide ongoing basic billing education, both initial/orientation level and refresher level, offered to all Participating Provider staff. CONTRACTOR(S) shall develop and submit an annual schedule of Participating Provider training sessions for State approval. This will include options for in‑person, internet-based training, or other remote access. CONTRACTOR(S) shall provide an annual report to the State which reflects the completion of these training sessions over the calendar year
3. Tracking and trending Provider inquiries/complaints/requests for information and taking systemic action as necessary and appropriate.
4. Ensure that Provider calls are acknowledged within three (3) business days of receipt, are resolved, and the result communicated to the Provider within thirty (30) business days of receipt.
5. Hold a Provider forum no less than semi-annually. The forum must be chaired by the CONTRACTOR(S)’ Administrator/CEO or designee. The purpose of the forum is to improve communication between the CONTRACTOR(S) and its Participating Providers. The forum shall not be the only venue for the CONTRACTOR(S) to communicate and participate in the issues affecting the network. Provider forum meeting agendas and minutes must be approved by KDHE in advance of the meeting(s).
6. Report information discussed during these forums to Executive Management within the organization.
7. Conduct meetings with Providers to address issues (or to provide general information, technical assistance, etc.) related to Federal and State requirements, changes in policy, reimbursement matters, PA, and other matters as identified or requested by the State.

### Requirements for a Provider Manual

1. Develop and submit to the State for approval, a Provider Manual that:
2. Contains dated CONTRACTOR(S) policy and procedure information, including, in part, credentialing criteria, UM policies and procedures, billing and payment procedures, Provider and Member Grievance and Appeal processes, and network management requirements.
3. Is distributed electronically to all Participating Providers following approval of the State no later than thirty (30) calendar days following the CONTRACT effective date, and then to Participating Providers and Non-Participating Providers upon request thereafter.
4. Is updated regularly, and distributed electronically in whole or in part to Participating Providers at least thirty (30) calendar days in advance of any policy or procedure change substantive revisions to the Provider Manual must be submitted to the State for approval. Changes must be posted on the CONTRACTOR(S) website and notify Providers via bulletins.
5. Is posted as an electronic version of the Provider Manual to the CONTRACTOR(S)’ web site with hard copies made available upon request.
6. Is consistent with State Medicaid Provider Manuals in regards to services covered and who can provide the services.

### State Approval Process of Provider Materials

1. The CONTRACTOR(S) shall submit to the State for review and prior written approval all materials meant for distribution to Providers, including, but not limited to, Member Handbooks, Provider Directories, any other additional, but not required, materials and information designed to educate Providers.
2. All Provider materials must be submitted to the State in electronic file media, in the format prescribed by the State. The CONTRACTOR(S) shall include a plan that describes the CONTRACTOR(S)’ intent for the use of the materials.
3. The State reserves the right to notify the CONTRACTOR(S) to discontinue or modify written Provider materials.
4. Except as otherwise noted written materials must be submitted for review at least forty-five (45) calendar days for approval before their printing and distribution. The CONTRACTOR(S) should only request expedited reviews in rare circumstances and will be monitored for potential misuse. This requirement applies to:
5. Policy letters, coverage policy statements, or other communications about Covered Services distributed to Providers
6. All updates to the Provider Handbook
7. All bulletins
8. All policy information changes submitted via letter
9. All Provider CONTRACT templates
10. All Pay for Performance (P4P) programs with Providers
11. All CONTRACTS with Subcontractors
12. The CONTRACTOR(S) shall provide the State with advance notice of any changes made to written materials that will be distributed to all Providers.

### Electronic Specific and Website Requirements for Provider Information

1. The CONTRACTOR(S) and any Subcontractors are responsible for developing, hosting, and maintaining a public website.
2. The CONTRACTOR(S) shall include a description of its website and its functionality in the proposal and take into consideration the Member-specific information as required in Section 5.10.
3. The CONTRACTOR(S) website shall contain the following elements:
4. Electronic information must be in a machine-readable file and format.
5. Easy navigation.
6. Separate section each for Providers and Members.
7. Compliant with Americans with Disability Act (ADA) Title III website accessibility requirements and the State of Kansas Information Technology Office (KITO) Executive Council Accessibility Requirements. These requirements are located at the link: <https://www.oits.ks.gov/kito/itec/itec-policies/itec-policy-1210> CONTRACTORS websites will be subject to KITO’s review and approval for accessibility.
8. All information must be kept current and up-to-date.
9. The CONTRACTOR(S)’ website shall include the following on their public website:
10. Prominent links to the electronic Provider Handbooks.
11. CONTRACTOR(S) contact information.
12. Frequently Asked Questions (FAQs).
13. Benefit information and links to KMAP policies as appropriate.
14. Information on oral translation services and how to obtain those services.
15. Links to other related websites, including the KDHE-DHCF Medicaid and KDADS websites.
16. Information about Pharmacy drug formulary:

Which medications are covered, including both brand and generic names.

What tier each medication is on.

1. Provider Directory as required per Section 5.10.8, featuring the ‘Find a Doctor’ feature for Members.
2. Historical repository of bulletins.
3. Authorization necessity check and links to an authorization request tool or form.
4. The following will be accessible from the CONTRACTOR(S) website with specific links to:

Sign in KMAP enrollment and credentialing tool

Sign in for KMAP Member eligibility verification tool

Any other forms and Provider newsletters

MCO online computer based training

1. A separate posting of the CONTRACTOR(S)’ cultural competency policy.
2. Posting of assurance of non-discrimination policy.
3. Hot links to all Subcontractor websites.
4. Links to any definitions of claim denial or remark codes.
5. Maps with Provider representative regions outlined and full name/contact information for Provider representatives.
6. For Providers, the CONTRACTOR(S) shall maintain a secure area within their website which offers:
7. Information regarding the CONTRACTOR(S) records for the inquirer.
8. Ability to obtain claim or authorization status information.
9. Electronic copy of explanation of benefits that detail claim service payment or denials. Dates of service, procedure codes, amount billed, amount allowed, amount paid, and patient liability are all required on the explanation of benefits from the CONTRACTOR(S) and Subcontractors.
10. Ability to have Providers submit prior authorizations through the CONTRACTOR(S)’ secure website. If CONTRACTOR(S) does not have this capability currently, the CONTRACTOR(S) shall describe how it will meet this capability by July 1, 2019.

### Written Provider Materials Requirements

1. All written Provider materials must follow the requirements in Section 5.6 above.
2. Any significant policy or processing change with Provider impact requires a Provider bulletin.
3. State policy changes shall be communicated using the official KDHE-DHCF policy related to the Provider bulletin publication process:
4. Bulletin will be supplied by the State to the CONTRACTOR(S).
5. CONTRACTOR(S) shall use this same exact document to publish/distribute.
6. Bulletin will be on the CONTRACTOR(S) website and distributed via email in advance of policy effective date.
7. CONTRACTOR(S) will notify KDHE-DHCF Policy Team when the publication process is complete.
8. Any bulletins that are not related to a State policy change still must be reviewed and approved by the State prior to publication.
9. Bulletins should be emailed through an email distribution list, posted on the CONTRACTOR(S) public website, and mailed to Providers as appropriate.
10. The CONTRACTOR(S) shall not distribute any marketing materials without first obtaining the State’s approval. The material must be co-branded with the KanCare logo unless otherwise approved.

### Customer Service Center – Provider Assistance

1. The CONTRACTOR(S) shall staff, operate, and maintain a Customer and Provider Service Center that is responsible for handling and responding to inquiries/correspondence received by telephone, fax, written, in person, or electronic means concerning the KanCare programs.
2. The CONTRACTOR(S) must operate a toll-free telephone service, for use by Members, potential Members, Providers, community-based service organizations, and other public or private agencies from 8:00am-5:00pm Central Time Monday through Friday, except for State-approved holidays. The CONTRACTOR(S) is responsible for providing sufficient in‑bound toll-free lines to meet the performance standards outlined below.
3. Automated Voice Response System (AVRS) may be incorporated into the customer service plan. If an AVRS is used, separate queues must be available for English and Spanish calls.
4. The AVRS must be capable of providing specific information such as the fax number, hours of operation, etc., as well as allowing the caller to access a call center representative.
5. Shall provide option in initial menu to allow Providers and Members to contact a call center representative immediately.
6. Staffed with personnel who are knowledgeable about the CONTRACTOR(S)’ program, Covered Services and services covered outside the CONTRACT.
7. The Customer Service Center shall be a separate, identifiable, and centralized unit which is staffed with a sufficient number of trained staff to fulfill the functions of this unit. The staff answering calls must receive appropriate training, including, but not limited to, benefits and services, enrollment process, Grievance and Appeal process, and logging and documenting calls.
8. The CONTRACTOR(S) will research, resolve, and respond to all received inquiries made by Providers and other parties.
9. The CONTRACTOR(S) will submit call center representative training plan, evaluation standards and tools to the State for approval ninety (90) days after CONTRACT award.
10. The CONTRACTOR(S) must provide language assistance and translation services necessary to ensure meaningful access at no cost to the LEP Members.
11. The CONTRACTOR(S) will have dedicated Provider lines with sufficient staffing to meet CONTRACT standards.
12. The CONTRACTOR(S) must record all calls (inbound and outbound, including voicemails) for future retrieval that are received and handled within the call centers that handle calls directed to the CONTRACTOR(S)’ primary published Member Services and Provider Services.
13. The CONTRACTOR(S) must provide a system to track and document all phone contacts, including incoming calls, outgoing calls, incoming email, outgoing email, web-based contacts and voice messages. The call tracking system shall have the capability to generate statistical reports regarding, for example, call volumes, length of time to answer, abandonment rates, length of the calls, nature of the contact, and who answered the contact.
14. Call center report will be submitted to the State using State specifications and definitions. Reasons for the call shall be standardized between CONTRACTOR(S), and all statistics will be submitted as required by the State. Customer Service Center will maintain reporting systems with the capability to track all statistics necessary to address performance requirements listed in Section 5.10.10.J.
15. Customer Service Performance Standards: The CONTRACTOR(S) and their Subcontractors shall meet the following requirements for Customer Service:
16. 100% of incoming and outgoing calls must be documented and recorded.
17. 99% of calls will be answered by an individual or an electronic device without receiving a busy signal.
18. 80% of all calls will be answered in thirty (30) seconds or less. The average speed for answering calls will be thirty (30) seconds or less. The average abandonment rate will be 4% or less.
19. 90% of calls answered will be resolved by the CONTRACTOR(S) during the initial contact.
20. 100% of received phone calls are recorded and the recordings maintained.
21. 100% of calls left on voice mail during or after working hours will be retrieved and returned within one (1) business day.
22. 95% of all inquiries shall be resolved within two (2) business days of receipt.
23. 98% of all inquiries shall be resolved within five (5) business days.
24. 100% of all inquiries shall be resolved within fifteen (15) business days.
25. 100% of all email inquiries will be answered within one (1) business day.
26. 90% quality monthly average for fully trained staff based upon the standards of the State approved CONTRACTOR(S) training plan.
27. 95% hold times equal to or less than one (1) minute for all inbound and outbound calls.
28. The data are used to monitor the above topics by obtaining information from the Members and Providers, resolving issues, identifying, and addressing trends. If deficiencies are identified, the CONTRACTOR(S) must report such findings to the State and perform corrective action until compliance is met.
29. The CONTRACTOR(S), through Customer Services, shall facilitate the development of Warm Transfers from Help Lines when the caller’s crisis cannot be addressed by the Help Lines. The State will consider options other than use of Warm Transfers for coordination of Help Line services that are proposed by the CONTRACTOR(S), as long as the other requirements of this section are met.
30. The CONTRACTOR(S) must provide a voicemail system that allows messages to be left during and after business hours.
31. The CONTRACTOR(S) must provide email customer service support with sufficient capacity to handle the incoming volume.
32. Toll-Free Fax Line: The CONTRACTOR(S) must provide a toll-free HIPAA compliant, secure fax system with sufficient capacity to handle the incoming volume.
33. Fax Service Performance Standards: The CONTRACTOR(S) shall meet the following requirements for fax line service:
34. 98% of the time, fax lines shall meet customer demand.
35. 95% of all inquiries shall be resolved within two (2) business days of receipt.
36. 98% of all inquiries shall be resolved within five (5) business days.
37. 100% of all inquiries shall be resolved within fifteen (15) business days.
38. The CONTRACTOR(S) shall have, maintain, and publish the availability of a HIPAA‑compliant email system to receive secure materials from Providers electronically.
39. All fax, written communication, and similar documents received shall be imaged/scanned into electronic files for documentation and retrieval purposes, and stored using HIPAA-compliant methods.

### Provider Representatives

1. In addition to the Customer Service Center specifications outlined in Section 5.6.5 above, the CONTRACTOR(S) shall have a sufficient number of dedicated Provider representatives who will make office visits and train Providers.
2. Provider representatives shall train Providers on claim billing, Medicaid benefits, authorization requirements, Grievance, Appeal, and State Fair Hearing rights and procedures, recoupments explanation of benefits, claim reconsiderations, and claim payment/denial.
3. CONTRACTOR(S) shall post on the website the contact information for the Provider representatives, and a State map showing the regions covered by each representative.
4. Provider representatives must have prior customer service experience and insurance claim experience with training in billing.
5. The CONTRACTOR(S) shall submit the names of the Provider representatives and full list of all Provider contacts with a brief description of the contact to the State for review on a quarterly basis.
6. The CONTRACTOR(S) shall submit any changes or vacancies from the Provider representative unit to the State within ten (10) days of any changes.
7. CONTRACTOR(S) shall ensure that all Provider offices receive one (1) phone call/visit at a minimum per calendar year quarter. Some larger facilities/clinics may require more frequent contact.
8. CONTRACTOR(S) shall ensure that Provider representatives will attend all major Provider association meetings.
9. CONTRACTOR(S) shall ensure that all Provider representatives will attend at least one all-CONTRACTOR Provider training.
10. All CONTRACTOR(S) shall work together to create and present State-approved Provider training at minimum quarterly in locations throughout the State.

## CONTRACTOR(S) Proposals for Value Based Models and Purchasing Strategies

CONTRACTOR(S) are required to implement innovative Provider payment and/or innovative delivery system design strategies that incorporate performance and quality initiatives in service delivery models, referred generally herein as Value Based Models and Purchasing Strategies. Innovative programs may impact the delivery system but may not require innovative Provider payment. The State is interested in both so long as the strategies support the goals and objectives of KanCare 2.0. The State seeks to promote the goals of helping Kansans achieve healthier, more independent lives by providing services and connecting to supports for Social Determinants of Health and Independence in addition to traditional Medicaid benefits. These goals and the 1115 Waiver renewal hypotheses below are key focus areas of the RFP and should be considered in bidder responses in this section.

1. Expanding Service Coordination to include assisting Members with accessing affordable housing, food security, employment, and other Social Determinants of Health and Independence will increase independence and stability, and improve health Outcomes.
2. Increasing employment and independent living supports for Members with Behavioral Health needs, or who have intellectual, developmental, or physical disabilities or traumatic brain injuries will increase independence and improve health Outcomes.
3. Providing Service Coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health Outcomes for these youth.

CONTRACTOR(S) is required to propose Value Based Models to the State for review and approval prior to implementation. CONTRACTOR(S) will have flexibility in designing strategies for the topic areas identified in this section in their proposals but must provide sufficient information for the State to be able to evaluate and determine if the arrangement as proposed meets the elements in the framework described below in Table 1 and supports the goals and objectives of KanCare 2.0.

The State will evaluate each proposal based on its merits, the completeness of the information provided and the likelihood that the arrangement will be implemented during the CONTRACT period. CONTRACTOR(S) should be aware that the State reserves the right to modify the proposed metrics and reporting requirements described in the framework to develop standardized reporting across CONTRACTOR(S) for similar arrangements. To promote effective implementation of these strategies and reduce Provider abrasion concerns, the State may select a proposal(s) to be standardized across CONTRACTOR(S).

CONTRACTOR(S) must address each Value Based Model and Purchasing Strategy identified in paragraph A (below) of this section. If the CONTRACTOR(S) does not have a specific proposal for a particular Value Based Model and Purchasing Strategy, that should be indicated in the response. Preference will be given to the CONTRACTOR(S) that provides substantive and responsive proposals for each of the Value Based Models and Purchasing Strategies in paragraph A of this section, including subcategories 6.a.-c. under Telehealth.

CONTRACTOR(S) may submit a proposal that includes more than one Value Based Model or Purchasing Strategy identified in paragraph A; however, if a CONTRACTOR(S) elects to address more than one Value Based Model or Purchasing Strategy in a singular proposal, they should describe how each Value Based Model or Purchasing Strategy is employed in an innovative manner to be considered as meeting the requirement to address each Value Based Model or Purchasing Strategy. For each Value Based Model and Purchasing Strategy, the CONTRACTOR(S) must address the following elements described in Table 1.

### Table 1

|  |  |
| --- | --- |
| **Framework for Value Based Model and Purchasing Strategy Proposals** | |
| 1. Topical area addressed | As identified in paragraph A below. |
| 1. Description of arrangement and objectives | Provide a detailed description of the arrangement, how it differs from traditional service delivery and/or payments, and the goals and objectives the CONTRACTOR(S) seeks to achieve through the arrangement. The CONTRACTOR(S) should describe how these goals and objective align with the KanCare 2.0 hypotheses and overall quality of care goals and objectives. |
| 1. Identify specific populations and services included in the arrangement | Include all populations (including geographically isolated populations) and services/Providers that would be included in the arrangement. The proposal may be limited to certain services (e.g. hospital inpatient services, physician services, Pharmacy services, etc.), specified populations and/or subpopulations (e.g. individuals with Chronic Conditions, dual eligibles, disabled adults, foster care, etc.), and/or other categories as appropriate for the Value Based Model and Purchasing Strategy. These services may include Value-Added Benefits, including benefits that would support Social Determinants of Health and Independence. |
| 1. Identify role of Service Coordination strategies, as applicable | Addressed in Section 5.4.1, CONTRACTOR(S) should indicate how the proposed arrangement relies on Service Coordination strategies. For example, potential synergies may exist at the local levels that address Service Coordination, Social Determinants of Health and Independence, and explicit physical, Behavioral Health, or LTSS services. |
| 1. Identify role of health information technology/health information exchange (HIT/HIE), as applicable | In consideration of the information provided in Section 5.15.1 regarding HIT/HIE, the CONTRACTOR(S) should identify what HIT/HIE components are necessary for successful implementation of the model. |
| 1. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives | CONTRACTOR(S) should include in their proposals how they will coordinate and collaborate with existing relevant Value Based Purchasing and Quality Initiatives in the State, such as the Kansas Healthcare Collaborative, the Rural Health Initiative, Project ECHO, or others. |
| 1. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state. | Identify Providers that are participating (if this model is already implemented) or if the CONTRACTOR(S) has identified interested Providers. If the arrangement has already been implemented by the CONTRACTOR(S) in another market, include a description of Outcomes associated with the existing model. The proposal should also include a stakeholder engagement strategy for areas where the model will be implemented. |
| 1. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement. | Metrics, Outcomes, or other measurements should be readily available to Providers, the CONTRACTOR(S) and the State and should not be administratively burdensome. However, the CONTRACTOR(S) must describe why the specific metrics/measures were selected and how they relate to the model. The CONTRACTOR(S) should also describe how they will monitor Provider performance and the impact on Members. Additionally, describe how the CONTRACTOR(S) will provide the data, Outcomes, and evaluation to the State. If the model could skew any performance measures otherwise reported, the CONTRACTOR(S) should identify the interdependencies for State consideration. Proposals should also describe a stakeholder engagement plan for receiving input in the development of performance metrics. |
| 1. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start. | Projections are best estimates by the CONTRACTOR(S). The description should include a proposed implementation timeline that addresses research, development, Provider engagement and/or enrollment in the model and roll-out (including phase-in and staggered deployment), but such timeline must assume full deployment within (12) months of the implementation date of the CONTRACT. |

As described above, it is the intent of the State that measures, including any standardized measures and reports for Value Based Models and Purchasing Strategies, would be primarily based on nationally accepted measure sets (for example HEDIS and National Outcome Measures [NOMS]) and not be self-defined in nature. This is intended to align health and other measures in the State with national standards, to minimize the impact of reporting on the Provider, and to allow for common data across the enterprise.

1. Value Based Models and Purchasing Strategies:
2. Alternative Payment Models (APMs): APMs are innovative approaches to Provider payments that hold promise for controlling or reducing costs while improving Outcomes. CONTRACTOR(S) may propose APMs but the models, in order to be considered an APM, must include quality and/or outcome measures as part of the reimbursement strategy. Such models could include episodic bundled payments, shared savings strategies with Providers, or risk based payment strategies to Providers capable of managing such payment arrangements. For proposals including shared savings arrangements, CONTRACTOR(s) must identify financial, quality and utilization thresholds, including the marginal savings rate and proportional gain-share arrangements. For proposals that would include a risk arrangement, the CONTRACTOR(S) must identify the Providers that would be taking risk and describe why the CONTRACTOR(S) believes that the particular Provider type can accept risk. Any proposed APMs that impose risk on the Provider must be consistent with the physician incentive plan requirements specified in 42 CFR § 438.3(i) and must be approved by the State prior to implementation. In addition to more traditional Provider types that are reimbursed according to APMs, the State is particularly interested in payment models for NFs, PRTFs, and ICF/IDDs.
3. Social Determinants of Health and Independence: The State seeks innovative CONTRACTOR(S) models to address Social Determinants of Health and Independence that impact the overall health and well-being of Members and result in decreased medical expenditures. Programs that address Social Determinants of Independence are personal plans that are tailored to an individual’s vision for their good life. Such strategies may include direct interventions by the CONTRACTOR(S) or linkages to local resources for Members that result in employment opportunities, housing supports, food and nutritional security, educational opportunities, and advancement in education levels. Such interventions may be accomplished through the use of web-based technologies that link Members to available resources, community health workers or similar Providers that are CONTRACTOR(S) staff or embedded with Participating Providers, or other interventions that address Social Determinants of Health and Independence. The State is interested in innovative strategies that focus on Members that are in foster care, pregnant, managing chronic diseases, experiencing transient housing status, showing high ER utilization, and individuals served under the PD and IDD Waivers. Proposals do not have to address Social determinant of Health and Independence strategies for each population type identified herein; however, the State is interested in strategies that focus on the needs of those populations.
4. Behavioral Health Services: The State seeks innovative Provider contracting strategies to address Behavioral Health service needs including Mental Health and Addiction Services. The alternative payment strategies shall be designed to reduce total cost of care, and address gaps and improvement in access to services, quality of Providers, incentives for “warm handoff” transitions from institutions to less-restrictive and less costly treatment programs in community-based programs and services, seamless follow-up care, and diversions from institutions, particularly ED diversion resulting in reduced inpatient Admissions. Service focus of the strategies shall include, but not limited to, effective Service Coordination with a particular focus on managing individuals behavioral and physical health needs, Peer Support, Supported Employment, Supportive Housing and other evidence-based practices.
5. Long-Term Supports and Services: The State seeks innovative contracting strategies to address LTSS service needs including HCBS, Adult Care Home, and institutional services. The alternative payment strategies shall address gaps and improvement in access to services, quality of Providers, incentives for transitions from institutions to community-based programs and services, diversions from and significant reduction in the reliance of institutions for treatment, ensuring choice of in-home vs. residential services. Service focus of the strategies shall include, but not limited to Autism, Agency Directed Personal Care, Assisted Living, Residential Health Care, Home Plus, IDD Residential and other community service settings.
6. Physical and Behavioral Health Integration Strategies: The State seeks innovative models for integration of physical and Behavioral Health services. A 2015 Government Accountability Office report (GAO-15-460) showed that nationally, over half of the Medicaid-only Members in the top 5% of expenditures had a mental health condition and one-fifth had a SUD. That report also observed that “Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens), the health care system is often too fragmented to effectively and efficiently serve them.” A particular area of interest is how to better identify, treat, and transition Members to appropriate Behavioral Health services and Providers when presenting at the hospital with an emergent medical condition. In addition, proposals should consider approaches to promote use and collaboration among different Provider systems within the delivery system, such as FQHCs and Community Mental Health Centers (CMHCs).
7. Telehealth Projects: The State seeks innovative CONTRACTOR-developed models to expand the use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring as described below. Such models should focus on strategies to enhance access to services for rural areas, access to Behavioral Health services, and support chronic pain management interventions. The State currently reimburses for certain telehealth applications including: outpatient visit, individual psychotherapy, and pharmacological management services as long as the patient is present at the originating site. The State also reimburses for some telemonitoring services for specific HCBS and FE populations.

Telemedicine: The State is interested in positively impacting Member access by exploring telemedicine strategies that expand the full scope of practice by connecting network Providers with Members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication. Such projects can greatly enhance access, save time, money and improve Outcomes in communities with limited access to health care.

Telemonitoring: Technologies that target specific disease type (i.e. congestive heart failure) or high utilizers of health services, particularly ER services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing Provider. The Provider, who might be a physician, nurse, social worker, or even a non-clinical staff member, can filter patient questions and report to a clinical team as necessary. The goal would be to reduce Admissions, ER utilization and improve overall health of the Member.

Telementoring: Technologies such as the Project ECHO model to connect community PCPs with specialists remotely located to provide consultations, grand rounds, education, and to fully extend the range of care available within a community practice. The State is also interested in ways that the use of telementoring can attract and retain Providers in rural health shortage areas. This could include creating learning and joint consultation strategies that may make working in more isolated environments or practices more attractive.

Other Telehealth Projects: As telehealth capabilities increase, CONTRACTOR(S) may have access to additional models not identified above. The State encourages additional application of telehealth strategies but additional telehealth projects are not required to be included in the CONTRACTOR(S)’ proposal.

1. State-Based Data Registries, Tools, and Resources:
2. The State shall make available the following registries, tools, and resources to the CONTRACTOR(S) to assist in the implementation of Value Based Models and Purchasing Strategies:

Defined Cerner condition registries currently under consideration for inclusion by the State in its Kansas Modular Medicaid System development.

Both canned and ad hoc reporting available through the State enterprise data warehouse.

Public Health Registries

Health Information Exchanges

KMAP website containing updated eligibility information

KMAP Provider Registry

1. Additional resources may be added as they are available. The State will keep CONTRACTOR(S) informed of such resources.
2. Reporting Requirements:
3. The State will require CONTRACTOR(S) to provide reports to document and evaluate the effectiveness and Outcomes of strategies implemented under the CONTRACT.
4. The State will review proposed metrics included in submitted strategies and may select some or all of those metrics as well as potentially include additional metrics as part of the final reporting process. The metrics and reports will constitute the reporting requirements for the Value Based Models and Purchasing Strategies approved for implementation.

## Utilization Management

### Utilization Management Program Description

1. The CONTRACTOR(S) shall have a comprehensive integrated UM program that reviews services for medical necessity and assessed needs. A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the CONTRACTOR(S) and entities to which the CONTRACTOR(S) delegates or subcontracts UM activities. The UM program description shall include at a minimum: The UM program will be under the direct oversight of an applicable Kansas licensed professional with the Chief Medical Officer having complete oversight of the UM program and activities.
2. The UM program shall include an integrated approach, where the Member record is one record, housed in one documentation system.
3. The description of UM services, which services require a PA, a registration or some other type of CONTRACTOR(S) notification.
4. The written program description shall address the procedures used to evaluate medical necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.
5. The manner in which a Provider or a Member may request services.
6. The time frames from the point of a request to the decision including both oral and written notification where indicated and in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or State policy.
7. Description of the staff members’ licensure and credentials to manage any areas within the UM operations.
8. Assurance that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services or services for an assessed need to any Member.
9. For peer reviews, the CONTRACTOR(S) and Subcontractors (e.g. Pharmacy Benefit Managers) will primarily utilize Kansas-licensed physicians and pharmacists and dentists to render any adverse determination regarding service requests. However, CONTRACTOR(S) may utilize a non-Kansas licensed physician or pharmacist or dentist for such determinations on a short-term basis in cases of temporary absence or business disruption so long as the use of this option is reported to the State on a per-use basis; the non-Kansas licensed physician and pharmacist and dentist is of equal licensure as the person for whom he/she is substituting; the non-Kansas licensed physician and pharmacist and dentist is familiar with the KanCare program and has an existing relationship with the CONTRACTOR(S) or an affiliated health plan; and the absence or disruption does not exceed ten (10) business days or as otherwise approved by KDHE. If CONTRACTOR(S) or subcontractor intends to utilize the short-term option, the CONTRACTOR(S) shall first provide KDHE a description of how it will be structured and implemented.
10. The CONTRACTOR(s) shall notify and receive approval by the State for any UM activities that would be managed by a Subcontractor.

### Utilization Management Program Evaluation

1. The CONTRACTOR(S) shall monitor and evaluate on an ongoing basis the appropriateness of care and services. The evaluation shall be a fluid document that is updated as UM services are evaluated on a monthly, quarterly, semi-annually and annual basis. The UM Plan and evaluation results must be submitted at least annually to the State for review. The program evaluation shall:
2. Identify and describe the mechanisms to detect services that are the drivers of utilization cost and the services that are identified as being underutilized.
3. Identify rationale and evidence to support the decision to apply PA to certain services.
4. Include analysis validating compliance with the MHPAEA.

### Utilization Management Activities

1. All UM activities shall function in a comprehensive integrated manner, utilizing evidenced based practices guiding policy and procedure. The CONTRACTOR(S) shall demonstrate integrated operations and shall coordinate with Providers to ensure integrated care in any setting. The CONTRACTOR(S) shall include Preventive Care within the UM program and activities.
2. The CONTRACTOR(S) must demonstrate how the needs of the KanCare population will be identified and addressed.
3. The CONTRACTOR(S) shall ensure access to all services that are available through this CONTRACT.
4. The CONTRACTOR(S) shall disseminate the Kansas medical necessity definition, medical necessity criteria, authorization policies, procedures, and any applicable practice guidelines to all affected Providers and, upon request, to Members and potential Members.
5. The CONTRACTOR(S) will provide educational materials and webinars to Providers concerning obtaining PA for services, medical necessity criteria for services, and required timelines to ensure smooth delivery of services.
6. The CONTRACTOR(S) shall ensure that decisions for UM, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
7. The CONTRACTOR(S) shall provide a forum to receive Provider suggestions for policies and procedures at least annually, and shall document all changes made subsequent to Provider input.
8. The CONTRACTOR(S) shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with requesting Providers when appropriate.
9. The CONTRACTOR(S) shall disclose all criteria it uses for UM, submit the policies, procedures, and any applicable practice guidelines with this proposal and submit any revisions to the State for approval prior to implementation.
10. The policies, procedures and practice guidelines shall be:

Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

Consider the needs of the Members.

Adopted in consultation with Participating Providers, and reviewed and updated periodically as appropriate.

#### Social Determinants of Health and Independence

1. The CONTRACTOR(S) shall develop a process for identifying Social Determinants of Health and Independence needs when interacting with Members and connecting them to necessary resources when appropriate. Such needs could include, but not limited to safe housing, food security, transportation, employment and career training, and education, within the UM program and UM activities.

#### Medication-Assisted Treatment

1. Medication-Assisted Treatment (MAT) combines the use of medications with counseling and behavioral therapies to treat SUDs such as alcohol dependence and opioid use disorders.
2. The CONTRACTOR(S) shall describe any innovative strategies the CONTRACTOR(S) will implement to improve or expand the infrastructure of MAT Providers for opioid use, alcohol dependence and other SUDs or to improve Member access to MAT, particularly in the rural and frontier areas of the State. This shall include the ability for easy identification of Providers certified for MAT and the availability to treat new Members and the ability for Members to access care.

#### Emergency Room Protocol

1. The CONTRACTOR(s) shall develop an ER protocol based on evidenced based guidelines with the goal of reducing unnecessary ER visits and that assures integrated services for behavioral and physical health needs. For example, assurance that acute physical health needs are identified and treated as needed prior to transferring Members for a Behavioral Health service, and assurances that Members admitted to a medical-surgical unit with Behavioral Health needs receive appropriate Behavioral Health consultation and services.

#### Emergency and Post-Stabilization Services

The CONTRACTOR(S) may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the Outcomes specified in 42 CFR § 438.114(a)(i-iii) of the definition of emergency medical condition and/or a representative of the CONTRACTOR(S) instructs the Member to seek emergency services.

1. The CONTRACTOR(S) may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
2. The CONTRACTOR(S) may not refuse to cover emergency services based on the ED Provider, hospital, or Fiscal Agent not notifying the Member's PCP, MCO or applicable State entity of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services.
3. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.
4. The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CONTRACTOR(S) as responsible for coverage and payment.
5. Post stabilization services means Covered Services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The post-stabilization care services rules set forth at 42 CFR § 422.113(c).
6. Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR § 422.113(c). CONTRACTOR(S) is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by a CONTRACTOR(S)’ Participating Provider or other entity representative.
7. The CONTRACTOR(S) is financially responsible for post-stabilization care services obtained within or outside the entity that are not pre-approved by a CONTRACTOR(S)’ Participating Provider or other entity representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the entity for pre-approval of further post-stabilization care services.
8. CONTRACTOR(S) is financially responsible for post-stabilization care services obtained within or outside the entity that are not pre-approved by a CONTRACTOR(S)’ Participating Provider or other entity representative, but administered to maintain, improve or resolve the Member's stabilized condition if the CONTRACTOR(S) does not respond to a request for pre-approval within one (1) hour; the CONTRACTOR(S) cannot be contacted; or the CONTRACTOR(S) representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, the CONTRACTOR(S) must give the treating physician the opportunity to consult with a CONTRACTOR(S)’ Participating Provider and the treating physician may continue with care of the Member until a plan physician is reached or one of the criteria of 42 CFR § 422.113(c)(3) is met.
9. CONTRACTOR(S) must limit charges to Members for post-stabilization care services to an amount no greater than what the organization would charge the Member if he or she had obtained the services through the CONTRACTOR(S)’ organization.
10. CONTRACTOR(S)’ financial responsibility for post-stabilization care services that it has not pre-approved ends when:
11. A plan physician with privileges at the treating hospital assumes responsibility for the Member's care.
12. A plan physician assumes responsibility for the Member's care through transfer.
13. CONTRACTOR(S) representative and the treating physician reach an agreement concerning the Member's care.
14. The Member is discharged.

#### Administrative Lock-In

1. The CONTRACTOR(S) shall have in place an Administrative Lock-In system for the situations described below. The CONTRACTOR(S)’ Lock-In system shall be consistent with State and Federal regulations. The CONTRACTOR(S) must notify the State at a frequency defined by KDHE-DHCF when a Member has been placed in Administrative Lock-In and if a Member in Lock-In transfers to FFS or another CONTRACTOR(S).
2. Situations in which CONTRACTOR(S) may place a Member in Administrative Lock-in include:
3. Persistent non-compliance: Member persistently refuses to follow prescribed treatments or comply with the CONTRACTOR(S) requirements.
4. Abusive or threatening conduct: Member engages in abusive or threatening conduct.
5. Fraud/Abuse: Member is found to be committing Fraud or Abuse of medical benefits.
6. Overutilization: Member utilizes Medicaid services at a frequency or amount that is not medically necessary.
7. The CONTRACTOR(S) shall provide education to the Member regarding their behavior prior to placing a Member in Administrative Lock-In.
8. If the Member has an SUD, mental health or disability diagnosis related to the persistent non-compliant behavior, the CONTRACTOR(S) will work with Behavioral Health and disability Providers to help the Member change behavior prior to placing the Member in Administrative Lock-In.
9. The CONTRACTOR(S)’ attempts to educate and change the Member’s behavior shall be documented.
10. During the Lock-In period, the Member may be required to use one Pharmacy, one hospital, and one PCP.
11. The Member has the right to appeal their placement into Administrative Lock-In.
12. The Member must be given notice and opportunity for a State Fair Hearing before placement into Administrative Lock-In.
13. The CONTRACTOR(S) must ensure that the Member has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.
14. Restrictions must not apply to emergency services furnished to the Member
15. CONTRACTOR(S) may review all ER, inpatient and outpatient claims of Locked-In Members.

### KanCare 2.0 HCBS Waiver Populations

1. In the event that the Member receiving HCBS Waiver services has participated in responding/complying with the CONTRACTOR(S) requests for re-evaluation prior to expiration, continues to demonstrate need for services at the appropriate scope, duration and frequency, and expresses a desire to retain the current Provider and service array, the CONTRACTOR(S) shall ensure that HCBS services are reauthorized prior to the expiration of current authorizations in order to ensure continuity of care and stability for Members and Providers regarding those services. If an authorization expires, and the Member has actively participated/complied with re-evaluations, the designated entity has offered impartial choice timely, and the chosen Provider has complied with requested documentation submission, HCBS will be considered as authorized consistent with the previous authorization until the pending reauthorization is fully operational, and claims for services provided between authorizations will be adjudicated consistent with the claims adjudication requirements as reflected elsewhere in this CONTRACT and Attachments hereto.
2. The CONTRACTOR(S) shall conduct prior authorization practices for those Members receiving HCBS services in a manner that assesses both the medical and functional needs of the Member, and considers whether the denial of equipment, supplies, or services would inhibit a Member’s community access, or the progression of the Member’s PCSP, if denied.
3. Once the CONTRACTOR(S) has authorized HCBS, claims for the fully authorized service will be adjudicated in accordance with the claims processing guidelines and applicable Member due process rights as expressed in this CONTRACT.
4. The CONTRACTOR(S) shall ensure that HCBS initial authorizations are electronically entered for delivery and billing in a timely fashion. This includes:
5. 99% of HCBS initial authorizations will be issued within fourteen (14) business days of the initial delivery date of service into the CONTRACTOR(S)' authorization system with the exception of: continuity of care for Members transitioning from one CONTRACTOR(S) to another; Members with gaps in eligibility that have been restored; Members who have been emergently placed by Adult Protective Services (APS) or other State or law enforcement agency in service on a non-business day; Members who have incurred a material change in condition necessitating a change in services overnight, weekend or holiday, or other similar circumstance in which retroactive authorizations may be necessary to address the needs of the Member; institutional transitions into the community; and delays in coding or correct coding as it relates to level of care. The CONTRACTOR(s) shall contact the appropriate State entity when aware of delays in level of care coding.
6. 95% of HCBS initial authorizations will be entered into the CONTRACTOR(S)’ authorization system one (1) day prior to the first date of service delivery, with the exception of continuity of care for: Members transitioning from one CONTRACTOR to another; Members with gaps in eligibility that have been restored; Members who have been emergently placed by APS or other State or law enforcement agency in service on a non-business day; Members who have incurred a material change in condition necessitating a change in services overnight, weekend or holiday, or other similar circumstance in which retroactive authorizations may be necessary to address the needs of the Member; institutional transitions into the community; and delays in coding or correct coding as it relates to level of care. The CONTRACTOR(s) shall contact the appropriate State entity when aware of delays in level of care coding.
7. 100% of approved PCSP authorizations are provided to Provider and Member prior to services beginning.

## Quality Assessment and Performance Improvement

### General Requirements

The CONTRACTOR(S) shall acknowledge its intent to abide by the requirements of the State’s Quality Management Strategy (QMS) once it is approved. Additionally, the CONTRACTOR(S) shall provide a detailed response to how the QAPI program will be designed addressing each of the elements below.

1. The State’s QMS: The CONTRACTOR(S) shall comply with the State’s QMS. The QMS includes, among other things, details on the State’s expectations and requirements for quality activities and timeliness. The QMS is reviewed annually, at a minimum, and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The CONTRACTOR(S) shall comply with any revisions to the QMS.
2. The CONTRACTOR(S) shall establish, document, and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to Members which, at a minimum, includes the following elements:
3. Performance improvement projects that focus on clinical and nonclinical areas.
4. Each performance improvement project must adopt principles of rapid cycle process improvement and be designed to achieve significant improvement, sustained over time, in health Outcomes and Member satisfaction, and must include the following elements:

Measurement of performance using objective quality indicators.

Implementation of interventions to achieve improvement in the access to and quality of care.

Evaluation of the effectiveness of interventions based on established performance measures.

Planning and initiation of activities for increasing or sustaining improvement.

See Section 5.9.5 for additional performance improvement project requirements.

1. The CONTRACTOR(S) shall report the status and results of each project to the State on an annual basis, or more frequently as requested by the State or EQRO.
2. The CONTRACTOR(S) shall collect and report performance measurement data, including performance measures relating to quality of life, rebalancing, and community integration activities for Members receiving LTSS.
3. The CONTRACTOR(S) shall develop and implement mechanisms to detect both underutilization and overutilization of services.
4. The CONTRACTOR(S) shall develop and implement mechanisms to compare services and supports received with those set forth in the Member’s treatment/service plan for individuals enrolled in LTSS Waivers.
5. The CONTRACTOR(S) shall develop and implement mechanisms to identify Members who are enrolled in LTSS Waivers but who are not receiving any Waiver services.
6. The CONTRACTOR(S) shall develop and implement mechanisms to identify and address Behavioral Health service needs of Members. The CONTRACTOR(S) shall ensure the Member receives all identified State approved Behavioral Health services for any unmet service needs.
7. The CONTRACTOR(S) shall develop and implement mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.
8. The CONTRACTOR(S) shall develop and implement mechanisms to assess the quality and appropriateness of care furnished to Members receiving LTSS, including assessment of care between care settings.
9. The CONTRACTOR(S) shall participate in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements for the State for HCBS Waiver, Behavioral Health and institutional programs. The CONTRACTOR(S) shall identify, track and review critical incidents to address potential and actual quality of care and/or health and safety issues.
10. The CONTRACTOR(S) shall report to the State on the results of efforts to support community integration for Members using LTSS.
11. The CONTRACTOR(S) shall develop a process to evaluate the impact and effectiveness of its QAPI.
12. Structure and staffing: The CONTRACTOR(S) shall ensure the following requirements are met:
13. Establish a QAPI unit within its organizational structure that is separate and distinct.
14. Employ sufficient, qualified staff and utilizes appropriate resource to achieve quality Outcomes.
15. Ensure the Chief Medical Officer, or other physician designee, is responsible for oversight of the CONTRACTOR(S) QAPI program.
16. Establish a Quality Committee Structure from the Board of Directors down to the local health plan that includes, at a minimum, committees to address quality management/quality improvement, service, delegation oversight, credentialing/re-credentialing, peer review, Member Advisory and subcommittees to address children or other special populations, as appropriate. All committees should have a clearly defined charter outlining the role, responsibility, membership and meeting frequency. As appropriate and based on the role of each Committee, membership should include an appropriate mix of community Providers, Members and caregivers reflective of the services delivered and populations served under the CONTRACT.
17. Develop an annual QAPI workplan outlining the requirements and timeline in which the CONTRACTOR(S) will complete all QAPI activities.
18. Develop an annual evaluation process to be completed within the first quarter of each new year from which findings and recommendation will be used to shape the annual QAPI program description and QAPI workplan. The QAPI evaluation should assess the extent to which the CONTRACTOR(S) met its goals and objectives and should include recommendations for continuous quality and service improvement.
19. Integrate quality management processes in all areas of the CONTRACTOR(S)’ organization.
20. Demonstrate improvement in the quality of care provided to Members through established quality management and performance improvement processes.
21. Regularly, and as requested, disseminate Subcontractor and Provider quality improvement information including performance measures, dashboard indicators and Member Outcomes to the State and key stakeholders, including Members and family members.
22. Develop and maintain mechanisms to solicit feedback and recommendations from key stakeholders, Subcontractors, Members and family members to monitor service quality and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance.

### State and Federal Monitoring

The CONTRACTOR(S) shall ensure its Subcontractors and delegates comply with all requirements for State and Federal Monitoring found at 42 CFR § 438.230 and as contained within this section. As part of its response the CONTRACTOR(S) shall acknowledge these requirements and demonstrate how it will ensure compliance with these provisions.

1. The CONTRACTOR(S) shall cooperate with any State or Federal monitoring of its performance under this CONTRACT, which may include but is not limited to external quality reviews (EQR), operational reviews, performance audits, and evaluations.
2. The CONTRACTOR(S) must identify, collect and provide any data, medical records, or other information requested by the State or its authorized representative or the Federal agency or its authorized representative in the format or process specified by the State/Federal agency or its authorized representative. The CONTRACTOR(S) shall ensure that the requested data, medical records and other information is provided at no charge and submitted in the required timeframe to the State/Federal agency or its authorized representative.
3. If requested, the CONTRACTOR(S) shall provide, at no cost, an adequate workspace at the CONTRACTOR(S)’ local offices for the State/Federal agency or its authorized representative to review requested data, medical records, or other information.
4. Federal law (Section 1902(a) (30) (C) of Title XIX of the SSA) requires entities which are external to and independent of the State and its CONTRACTOR(S) and subcontractors to perform, on an annual basis, a review of the quality of Medicaid MCS furnished by each such CONTRACTOR(S). Requirements relating to the EQR are further defined and described under 42 CFR § 433 and 438 updated in the new managed care final rule. The CONTRACTOR(S) shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR § 438, Subpart E.
5. The EQRO will conduct annual, external, independent reviews of the quality Outcomes, timeliness of, and access to the services covered in this CONTRACT.
6. The CONTRACTOR(S) shall collaborate with the EQRO to develop studies, surveys and other QAPI activities to access the quality of care and services provided to Members and to identify opportunities for CONTRACTOR(S)’ improvement. The CONTRACTOR(S) must also work collaboratively with the State and the EQRO to annually measure identified performance measures.
7. The CONTRACTOR(S) shall respond to recommendations made by the EQRO within the timeframe established by the EQRO. For the purposes of this CONTRACT, these requirements shall apply to all Medicaid and CHIP managed care services.
8. Federal law (Section 1902(a) (30)(C) of Title XIX of the SSA) requires entities which are external to and independent of the State and its CONTRACTOR(S) and Subcontractors to perform, on an annual basis, a review of the quality of Medicaid managed care services furnished by each such CONTRACTOR(S).

### Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles

The following definitions apply to this sub-section:

* Guiding principles define the general rules that govern the CONTRACTOR(S) approach to implementing the QAPI. These principles are unchanging over time, even if the goals and objectives of the QAPI change.
* Goals represent a broad primary outcome of the QAPI program. The goals provide the CONTRACTOR(S) with the general framework for how the QAPI should be developed.
* Objectives define the method used to achieve the broader goal(s) of the QAPI. Objectives provide the pathway the CONTRACTOR(S) should adopt to ensure the established goal(s) are achieved.

1. The CONTRACTOR(S) shall adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors:
2. Promote an organizational culture focused on continuous quality improvement, innovation, and service excellence at all levels of quality program design and implementation.
3. Empower staff excellence through hiring those who are Medicaid experienced and knowledgeable and investing in their development through relevant ongoing training, education, and mentorship.
4. Harness data from information systems and engage data analytic approaches to produce actionable information which is consistent, timely, valid, and reliable and supports evidence‑based decision making.
5. Utilize Rapid-Cycle Process Improvement methods to quickly identify, analyze and resolve operational inefficiency, improve the quality of care and improve the Member and Provider experience.
6. Focus on achieving year-over-year quantitative and qualitative improvements.
7. Implement a system of measurement and monitoring to assure the health, safety, and welfare of Members.
8. Pursue innovative approaches, including the use of telehealth, e-visits and alternative payment arrangements, to expand access to quality care and services.
9. Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members.
10. Maximize the quality of life of all Members by addressing Social Determinants of Health and Independence and through delivery of culturally appropriate, integrated, holistic, evidenced based care and services.
11. Promote the highest level of independence, dignity, productivity and community inclusion or preservation and maintenance of dignity, privacy and individuality based on Member and representative choice, rights and goals of care.
12. Use person-centered models to collaborate with Members, caregivers, and family to achieve the highest level of Member self-actualization and success.
13. The CONTRACTOR(S) shall adopt, at a minimum, the following goals within its QAPI program. The CONTRACTOR(S) shall respond to how these goals will be incorporated into its QAPI program and into those of its delegates and Subcontractors:
14. The CONTRACTOR(S) shall develop performance measurement and performance improvement strategies to maximize health Outcomes and the quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports.
15. The CONTRACTOR(S) shall promote the highest level of Member independence, productivity, Wellness and functional ability in the most integrated and least restrictive setting through harnessing data to monitor and ensure the delivery of holistic, integrated, person-centered, and culturally appropriate care to all KanCare populations.
16. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Members, family members of Members, caregivers and other stakeholders in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance.
17. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Providers, community-based organizations, Subcontractors and other network partners in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance.
18. The CONTRACTOR(S) shall use innovative strategies to improve access to and availability of services through the development of strong collaborative partnerships with Providers, Subcontractors and other network partners.
19. The CONTRACTOR(S) shall employ strategies to evaluate the ongoing efficiency and effectiveness of its Participating Providers and adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and services to all Members.
20. The CONTRACTOR(S) shall adopt, at a minimum, the following objectives through which the CONTRACTOR(S) shall meet the established QAPI goals. The CONTRACTOR(S) shall respond to how it will incorporate the following objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals:
21. Collect complete and accurate data on Members and Providers regarding service processes and Outcomes furnished through robust collection, analysis and reporting of data.
22. Maintain staff with the capacity and capability to provide and describe Kansas specific data at every level of collection, analysis, and reporting by the Plan, as well as, Participating Providers and vendors.
23. Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.
24. Deploy Rapid-cycle Quality Improvement principles throughout the organization.
25. Develop strong Provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered.
26. Adopt strategies to collect and integrate experience of care and satisfaction data from Members, caregivers, Participating Providers, and other network partners into the QAPI program.
27. Drive collaboration and innovation internally, across business units and externally with Members, caregivers, Participating Providers, stakeholders and community-based entities.

### Performance Measures

As part of its response to this proposal the CONTRACTOR(S) shall acknowledge its acceptance of the requirements below and provide a response to how it collects, aggregates, controls, validates, and uses performance measure data to improve the delivery of care and services. As part of its response the CONTRACTOR(S) must provide detail on how it has used performance measure data in a rapid-cycle fashion to (i) improve the integration of physical, behavioral and LTSS service delivery, and (ii) improve access and availability of LTSS and Behavioral Health Providers. The CONTRACTOR(S) must also provide detail on how it will use data to improve the quality of care and services delivered to all populations under the KanCare program.

1. The CONTRACTOR(S) shall comply with the requirements in the QMS regarding performance measures for medical, Behavioral Health and LTSS. The CONTRACTOR(S) shall use the methodology established by the State for all performance measures specified in the QMS.
2. At any time, CMS or the State may specify performance measures to be included in this CONTRACT. In addition to complying with the performance measures specified by the State, the CONTRACTOR(S) shall comply with any performance measures required by CMS or other Federal authority.

### Performance Improvement Projects

The CONTRACTOR(S) shall acknowledge the requirements below and respond to how it will incorporate rapid-cycle process improvement principles to ensure Performance Improvement Projects (PIPs) results are attained. As part of the response the CONTRACTOR(S) shall include at least two (2) PIP examples pertaining to LTSS and Behavioral Health populations that it has or is currently conducting including the results of interventions and improvements made and how lessons learned will be used to improve the Outcomes of PIPs conducted in the KanCare program.

1. The CONTRACTOR(S) shall perform at least three (3) clinical and two (2) non-clinical State approved PIPs. Clinical PIPs include but are not limited to projects focusing on prevention and care of acute and Chronic Conditions, high-risk populations, high-volume services, high-risk services, and continuity and coordination of care. Non-clinical PIPs include but are not limited to projects focusing on availability, accessibility, and cultural competency of services, claims payment timeliness, interpersonal aspects of care, Grievances and Appeals, and other complaints.
2. One (1) of the two (2) non-clinical PIPs shall be in the area of long-term care approved by the State.
3. The CONTRACTOR(S) shall develop a PIP on EPSDT Screening and Community outreach plans in addition to the above required PIP’s when overall CMS 416 rates drop below eighty-five percent (85%).
4. The CONTRACTOR(S) shall incorporate Rapid-cycle Process Improvement principles into all PIP activities.
5. The CONTRACTOR(S) shall use the State specified PIP template to document and report all PIP activities.
6. The CONTRACTOR(S) shall ensure that CMS EQR protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.
7. The CONTRACTOR(S) shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR(S) shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
8. The CONTRACTOR(S) shall report on PIPs as required in Attachment H.
9. After three (3) years, the CONTRACTOR(S) shall, using evaluation criteria established by KDHE-DHCF, or its designee, determine if one or all of the non-LTC PIPs should be continued. Prior to discontinuing a non-LTC PIP, the CONTRACTOR(S) shall identify a new PIP and must receive KDHE-DHCF’s approval to discontinue the previous PIP and perform the new PIP.
10. The State reserves the right to tie PIP requirements to P4P indicators where the CONTRACTOR(S) has failed to meet the benchmark or improvement standard. CAPs may also be instituted by the State for less than acceptable performance by a CONTRACTOR(S) on PIPs.

### Peer Review

The CONTRACTOR(S) shall describe how the Peer Review process will be designed to address the requirements below including the process used and data collected to evaluate the appropriateness of care and services rendered by Participating Providers. As part of its response the CONTRACTOR(S) shall indicate if a similar peer review process has been established in another State Medicaid program, how the data has been used to improve the delivery of care and services, the different Provider types included in the peer review process (i.e. LTSS, behavioral, transportation etc.) and how data from any delegate networks is incorporated into the process. Explain how the Peer Review process is integrated into the Program Integrity unit and how peer review data is maintained.

1. The CONTRACTOR(S) shall have a Peer Review process that includes:
2. Review of a Participating Provider’s practice methods and patterns, including quality Outcomes, prescribing patterns, morbidity/mortality rates, and all Grievances filed against the Participating Provider relating to medical treatment.
3. Evaluation of the appropriateness of care and service rendered by Participating Providers.
4. Implementation of corrective action(s) when the CONTRACTOR(S) deems it necessary to do so.
5. Development of policy recommendations to maintain or enhance the quality of care and service provided to Members.
6. Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a Participating Provider’s medical/case records, adherence to standards generally accepted by a Participating Provider’s peers and the process and outcome of a Participating Provider’s care.
7. Appointment of a Peer Review committee, as a subcommittee to the quality management/quality improvement committee, to review Participating Provider performance when appropriate. The Chief Medical Officer (CMO) or a physician designee shall chair the Peer Review committee and all decisions made by the Peer Review Committee shall not be over-turned by the Credentialing Committee or other Committee without the knowledge or consensus approval of the Peer Review Committee.
8. Membership in the Committee shall be drawn from the Provider network and include peers of the Participating Provider being reviewed.
9. Receipt and review of all written and oral allegations of inappropriate or aberrant service by a Participating Provider.
10. Education to Members, the Member Advocate(s), QM and other CONTRACTOR(S)’ staff, about the Peer Review process, so that Members and the CONTRACTOR(S)’ staff can make referrals to the Peer Review committee of situations or problems relating to Participating Providers.

### National Committee for Quality Assurance Accreditation

The CONTRACTOR(S) shall indicate whether they have achieved National Committee for Quality Assurance (NCQA) accreditation and LTSS Distinction for its Kansas Medicaid line of business, including the level of accreditation achieved. If they have not, the CONTRACTOR(S) shall obtain NCQA accreditation of at least “Accredited” and LTSS Distinction status within 24 months of the onset of delivering care to KanCare Members. The CONTRACTOR(S) shall describe in their proposal how they will proceed to attain NCQA “Accredited” and LTSS Distinction status in that time period.

1. Failure to obtain NCQA accreditation by the date specified above and failure to maintain accreditation thereafter shall be considered a breach of this CONTRACT and shall result in termination of this CONTRACT in accordance with the terms set forth in this RFP. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this CONTRACT in accordance with this RFP.
2. The CONTRACTOR(S) must submit the final hard copy NCQA Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report from NCQA. Updates of accreditation status, based on annual HEDIS scores must also be submitted within ten (10) days of receipt.

### Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers & Systems

The CONTRACTOR(S) shall respond to how it will approach HEDIS measure collection and improvement efforts including how the CONTRACTOR(S) will ensure a statistically valid sample frame for the required population stratification in Section 5.9.8(F). As part of its response the CONTRACTOR(S) shall include information on the largest improvements in the Use of Services and Effectiveness of Care domains from the most recent HEDIS measurement period including the interventions taken that resulted in the improvements/decrements and how such successes/opportunities for improvement will be leveraged in the KanCare program.

1. The CONTRACTOR(S) shall conduct HEDIS data collection as required in the QMS and as specified by NCQA.
2. HEDIS data collection shall be conducted at a minimum annually, and upon the State’s request. At a minimum, the CONTRACTOR(S) shall complete all HEDIS measures designated by NCQA as relevant to Medicaid.
3. The CONTRACTOR(S) shall report population-specific HEDIS measures as specified by the State (e.g., Comprehensive Diabetes Care measure rates for all Members, IDD/SMI populations and HCBS populations)
4. The CONTRACTOR(S) shall contract with an NCQA-certified HEDIS auditor to validate the processes of the CONTRACTOR(S) in accordance with NCQA requirements. Audited HEDIS results shall be submitted to KDHE-DHCF, NCQA and KDHE-DHCF’s EQRO annually by August 15 of each calendar year beginning in 2019.
5. The CONTRACTOR(S) shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. In the event the CONTRACTOR(S) fails to pass the medical record review for any given standard and NCQA mandates administrative data must be submitted instead of hybrid, the administrative data may be used.
6. The CONTRACTOR(S) shall submit to KDHE-DHCF by August 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".
7. The CONTRACTOR(S) shall conduct Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys at the frequency required in the QMS. When conducting the CAHPS, the CONTRACTOR(S) shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR(S)’ vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with Chronic Conditions survey using the most current CAHPS version specified by NCQA. The CAHPS survey shall include a statistically valid sample frame to stratify by Title XIX and Title XXI populations and results shall be reported by population stratification. Survey results shall be reported to KDHE separately for each required CAHPS survey and stratification level listed above. Survey results shall be submitted to KDHE-DHCF, NCQA and KDHE’s EQRO annually by August 15 of each calendar year in which the CAHPS survey was conducted.

### Adverse Incident Reporting and Management System

The CONTRACTOR(S) shall acknowledge the requirements below and provide a detailed response on how it will integrate data from the Adverse Incident Reporting and Management System, addressing how information will be used along with grievance data to improve the care and services delivered by network Providers, decrease incidents of abuse, neglect and exploitation and prevent future incidents.

1. The CONTRACTOR(S) shall utilize KDADS Adverse Incident Reporting and Management System to comply with State law and KDADS “HCBS Adverse Incident Reporting and Management” policy.
2. Incidents shall be classified as adverse incidents when the event or incident brings harm, or creates the potential for harm to any Member being served by a KDADS HCBS Waiver program, the Older Americans Act, the Senior Care Act, and the Behavioral Health Services programs.
3. The CONTRACTOR(S) shall report all Adverse Incidents within 24-hours of becoming aware of the incident or event.
4. If any member of the CONTRACTOR(S)’ staff or the staff of a Subcontractor that is not a Provider has reasonable cause to believe that a Member has been abused, mistreated, neglected or financially exploited, or has knowledge of the occurrence of other Adverse Incidents, the CONTRACTOR(S) shall report such incidents to the State by direct entry into the KDADS web based AIR system.
5. The CONTRACTOR(S) shall make reports of any abuse, neglect, exploitation, and fiduciary abuse to the Department of Children and Families (DCF) as required by DCF and KDADS Complaint Hotline for Adult Care Homes and “HCBS Adverse Incident Reporting and Management” Policy for HCBS.
6. The CONTRACTOR(S) shall investigate and follow up on any Behavioral Health Adverse Incidents reported in compliance with Behavioral Health guidelines. CONTRACTOR(S) shall only permit use of restraints and seclusions for members on the IDD and SED Waivers. Any use of physical or chemical restraint, isolation or seclusion in either Waiver is considered an adverse incident and must be reported via the AIR system within twenty-four (24) hours.
7. The CONTRACTOR(S) shall cooperate with KDHE-DHCF, KDADS and any investigating agency in documenting, investigating and addressing actual and suspected Adverse Incidents.
8. The CONTRACTOR(S) shall collect and analyze data regarding Adverse Incidents, track and identify trends, as outlined in KDADS “HCBS Adverse Incident Reporting and Management” Policy.

### Member Satisfaction Surveys

The CONTRACTOR(S) shall acknowledge the requirements below and share an example of a non-CAHPS based Member Satisfaction Survey it has conducted in the most recent twenty-four (24) months in a program with a similar population. As part of its response, the CONTRACTOR(S) shall include information on how the survey instrument was selected and/or created, the process used to validate the instrument, sampling methodology, data collection approach, stratification methodology, survey response rate, survey findings, barrier analysis, interventions taken to address findings and the Outcomes of these interventions on improving results. Discuss how lessons learned will help improve Member satisfaction in the KanCare program.

1. The CONTRACTOR(S) shall conduct Member satisfaction surveys as required in the QMS. The CONTRACTOR(S) shall comply with all Federal and State confidentiality law in conducting Member satisfaction survey(s).
2. Upon request by the State, the CONTRACTOR(S) shall make available the results of the Member satisfaction surveys to Providers, the State, Members and families/caregivers.
3. The CONTRACTOR(S) shall make the results of the Member satisfaction survey(s) data in a form that allows seamless integration with the State’s Enterprise Data Warehouse.
4. The CONTRACTOR(S) shall incorporate results of the Member satisfaction survey(s) in its QAPI program to improve care for Members.
5. The CONTRACTOR(S) shall conduct a sampling methodology that includes a statistically significant sample for both the HCBS and Behavioral Health populations.
6. The State participates in the National Core Indicators (NCI) and NCI-Adults with Disabilities (AD) consumer satisfaction surveys for the elderly and adults with disabilities. The Contractors shall ensure that a representative sample of MLTSS and Behavioral Health Members are included in this survey process. The CONTRACTOR(S) shall incorporate results of the NCI and NCI-AD surveys in its QAPI program and into those of its delegates and Subcontractors.

### Provider Satisfaction Surveys

The CONTRACTOR(S) shall acknowledge the requirements below and share an example of a Provider Satisfaction Survey it has conducted in the most recent twenty-four (24) months in a program with a similar set of service Providers. As part of its response, the CONTRACTOR(S) shall include information on how the survey instrument was selected and/or created, the process used to validate the instrument, sampling methodology, data collection approach, survey response rate, survey findings, barrier analysis, interventions taken to address findings and the Outcomes of the interventions. Discuss how lessons learned will help improve Provider satisfaction in the KanCare program.

1. The CONTRACTOR(S) shall comply with the requirements in the QMS regarding Provider satisfaction survey(s).
2. The CONTRACTOR(S) shall make a summary of the results of the Provider satisfaction survey available to the State and interested parties.
3. The CONTRACTOR(S) shall incorporate results of the Provider satisfaction survey(s) in its QAPI program to improve care for Members and CONTRACTOR(S) service to its Participating Providers.
4. The CONTRACTOR(S) shall conduct a sampling methodology that includes a statistically significant sample for both the HCBS and Behavioral Health Provider populations.

### Clinical and Medical Records

CONTRACTOR(S) shall respond to how it will meet the requirements set forth in this section.

1. The CONTRACTOR(S) shall maintain, and shall require Participating Providers and Subcontractors to maintain clinical and medical records in a manner that is current, detailed and organized; and, which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.
2. The CONTRACTOR(S) shall have clinical and medical record keeping policies and practices which are consistent with 42 CFR § 456 and current NCQA standards as well as all other related State and Federal laws for medical record documentation. The CONTRACTOR(S) shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:
3. Confidentiality of clinical medical records: CONTRACTOR(S) and Subcontractors must maintain the confidentiality of clinical and medical record information and release the information only in the following manner:

All clinical and medical records of Members shall be confidential and shall not only be released in compliance with HIPAA and other applicable record-protection laws.

Written consent of the Member is only required for the transmission of the clinical and medical record information of a former enrolled Member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable record-protection laws. Authorization is not required when the CONTRACTOR(S) is transitioning care to another KanCare CONTRACTOR.

The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the Practitioner or a facility requesting the information.

All releases of information for SUD specific clinical or medical records must meet Federal guidelines at 42 CFR § Part 2.

1. Clinical and Medical record documentation standards: The CONTRACTOR(S) shall maintain a system of access to clinical and medical records. The CONTRACTOR(S) must have in effect arrangements which provide for access to the clinical and medical records and clinical and medical record-keeping systems which include a complete record for each Member in accordance with provisions set forth in the CONTRACT. CONTRACTOR(S) shall include sufficient information to comply with the provisions of 42 CFR § 456.111 and § 456.211 regarding UR. The State, or its designated agent, and the Federal government shall be allowed access to this system.
2. Records Retention: The CONTRACTOR(S) shall retain, preserve and make available upon request all records relating to the performance of its obligations under the CONTRACT, including clinical and medical records and claim forms, for a period of not less than ten (10) years from the date of termination of the CONTRACT. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of such litigation, if the litigation is not terminated within the normal retention period. Electronic copies of documents contemplated herein may be substituted for the originals with the prior written consent of the State, provided that the microfilming procedures are approved by the State as reliable and are supported by an effective retrieval system. Upon expiration of the ten (10) year retention period, unless the subject of the records is under litigation, the subject records may be destroyed or otherwise disposed of without the prior written consent of the State.

## Member Services

### Member Services General Requirements

1. The CONTRACTOR(S) shall convey information to Members and Potential Members via written materials, telephone, internet, and face-to-face communications, and shall allow Members to submit questions and to receive responses from the CONTRACTOR(S).
2. The CONTRACTOR(S) shall ensure that the informational materials disseminated to all Members and Potential Members accurately identify differences among the categories of eligible persons.
3. The CONTRACTOR(S) shall provide Members with at least thirty (30) calendar days written notice of any significant change in policies concerning Members’ disenrollment rights, right to change PCPs or any significant change to any of the items listed in Member Rights and Responsibilities regardless of whether the State or the CONTRACTOR(S) caused the change to take place.
4. Per 42 CFR § 438.10, information such as the Member handbook, Provider directory or other electronic enrollee information must be available in paper form without charge upon request within five (5) business days.
5. All Member information under Section 5.10.3.D will be posted electronically on the CONTRACTOR(S) website and in such a format that can easily be printed by the Member.
6. If the CONTRACTOR(S) elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, then consistent with 42 CFR § 438.10 CONTRACTOR(S) must furnish information about the services it does not cover as follows:
7. To the State whenever it adopts the policy during the term of the CONTRACT.
8. To potential Members before and during enrollment.
9. To enrollees within ninety (90) calendar days after adopting the policy with respect to any particular service.

### Advance Directives

1. CONTRACTOR(S) shall comply with the requirements set forth in 42 CFR § 438.3(j) and 42 CFR § 422.128 for maintaining written policies and procedures for Advance Directives.
2. The CONTRACTOR(S) shall maintain written policies and procedures respecting Advance Directives with respect to all adult Members receiving medical care by or through CONTRACTOR(S) as set forth in 42 CFR § Part 489 subpart I .

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

1. CONTRACTOR(S) shall provide written information to each Member with respect to the following:
2. Their rights under the law of Kansas to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulation of Advance Directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. Changes in State law must be provided as soon as possible, but no later than ninety (90) days after the effective date of the change in State law. Applicable State Law of Kansas may be found in K.S.A. the Kansas Natural Death Act, K.S.A. 65–28,101 et seq. and the Kansas Durable Power of Attorney for Health Care Decisions, K.S.A. 58–625 et seq.
3. The Member’s right to file complaints concerning noncompliance with the Advance Directive requirements with the State survey and certification agency
4. The CONTRACTOR(S)’ written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the CONTRACTOR(S) cannot implement an Advance Directive as a matter of conscience. At a minimum, this statement must do the following:

Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians

Identify the State legal authority (K.S.A. 65–28,107 or K.S.A. 58–625) permitting such objection

Describe the range of medical conditions or procedures affected by the conscientious objection

1. Provide the information specified in Section 5.10.7 and its subsections and Section 5.10.10 to each Member at the time of initial enrollment. If a Member is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an Advance Directive, the CONTRACTOR(S) may give Advance Directive information to the Member’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Member or to a surrogate or other concerned persons in accordance with State law. The CONTRACTOR(S) is not relieved of its obligation to provide this information to the Member once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the Member directly at the appropriate time.
2. CONTRACTOR(S) shall document in a prominent part of the Member’s current medical record whether or not the Member has executed an Advance Directive.
3. CONTRACTOR(S) shall not condition the provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advance Directive.
4. CONTRACTOR(S) shall ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding Advance Directives.
5. CONTRACTOR(S) shall provide for education of staff concerning its policies and procedures on Advance Directive.
6. CONTRACTOR(S) shall provide for community education regarding Advance Directives that may include material required herein, either directly or in concert with other Providers or entities. Separate community education materials may be developed and used, at the discretion of the CONTRACTOR(S). The same written materials are not required for all settings, but the material should define what constitutes an Advance Directive emphasizing that an Advance Directive is designed to enhance an incapacitated individual’s control over medical treatment, and describe applicable State law concerning Advance Directives. The CONTRACTOR(S) must be able to document its community education efforts upon request by the State or applicable agents of the Federal government.
7. The CONTRACTOR(S) is not required to:
8. Provide care that conflicts with an Advance Directive.
9. Implement an Advance Directive if, as a matter of conscience, the CONTRACTOR(S) cannot implement an Advance Directive. State law allows any health care Provider or any agent of the Provider to conscientiously object.
10. While a Provider or agent of the Provider may object, State law requires that the Member be transferred to another physician. K.S.A. 65–28,107(a) requires transfer of a Member to another physician if the attending physician refuses to comply with the declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition of a qualified Member.

### State Approval Process of Member Materials

1. The CONTRACTOR(S) shall submit to the State for review and prior written approval all materials meant for distribution to Members, including but not limited to, Member Handbooks, Provider Directories, Member ID cards and, upon request, any other additional, but not required, materials and Information provided to Members designed to promote health and/or educate Members.
2. All materials must be submitted to the State in electronic file media, in the format prescribed by the State. The CONTRACTOR(S) shall include a plan that describes the CONTRACTOR(S)’ intent for the use of the materials.
3. The State reserves the right to notify the CONTRACTOR(S) to discontinue or modify written materials.
4. Materials after approval: Except as otherwise noted written materials must be submitted for review at least forty-five (45) Calendar Days before their printing and distribution. The CONTRACTOR(S) should only request expedited reviews in rare circumstances and will be monitored for potential misuse. This requirement applies to:
5. All enrollment materials distributed to all Members including the Member Handbook.
6. Policy letters, coverage policy statements, or other communications about Covered Services distributed to Members.
7. Standard letters and notifications, such as the notice of Enrollment, the notice of Redetermination, and the notice of Disenrollment.
8. The CONTRACTOR(S) shall provide the State with advance notice of any changes made to written materials that will be distributed to all Members.
9. The CONTRACTOR(S) must maintain and provide to the State upon request, documentation verifying that the Member Handbook is reviewed and updated at least once a year.

### Electronic Specific and Website Requirements for Member Information

1. The CONTRACTOR(S) and any Subcontractors are responsible for developing, hosting and maintaining a public website.
2. The CONTRACTOR(S) shall include a description of its website and its functionality in the proposal and take into account the Provider Services specific information as required in Section 5.6.3.
3. The CONTACTOR(S)’ website shall contain the following elements:
4. Electronic information must be in a machine-readable file and format.
5. Easy navigation.
6. Separate section each for Providers and Members.
7. Member materials must be worded at or below a sixth (6th) grade reading level, unless otherwise approved in writing by the State.
8. Member materials must be available online in both English and Spanish. Links to other prevalent language translations should be available. CONTRACTOR(S) is responsible for assuring accuracy and cultural appropriateness of the translations.
9. All information must be kept current and up-to-date.
10. Compliant with the American with Disabilities Act (ADA) Title III website accessibility requirements.
11. The CONTRACTOR(S) shall include the following on their public website:
12. Prominent links to the electronic Member Handbooks
13. CONTRACTOR(S) contact information
14. FAQs
15. Benefit information and links to KMAP policies as appropriate
16. Information on oral translation services and how to obtain those services
17. Medicaid and CHIP Provider Directory that is updated at least thirty (30) calendar days after receiving updated Provider information that is Member friendly and accessible by Provider type
18. Links to other related websites, including the KDHE-DHCF Medicaid and KDADS websites
19. Information about Pharmacy drug formulary:

Which medications are covered, including both brand and generic names

What tier each medication is on

1. Provider Directory as required per Section 5.10.8, featuring the “Find a Doctor” feature for Members
2. Posting of Cultural Competency policy
3. Posting of non-discrimination policy
4. Hot links to all Subcontractor websites
5. For Members, the CONTRACTOR(S) shall maintain a secure area within their website which offers:
6. Secure website area that enables an authorized inquirer to request an electronic copy of explanation of benefits that detail claim service payment or denials. Dates of service, procedure codes, amount billed, amount allowed, amount paid, and patient liability are all required on the explanation of benefits from the CONTRACTOR(S) and Subcontractors.
7. Ability to obtain claim or authorization status information.
8. Information regarding the CONTRACTOR(S)’ records for the inquirer.

### Written Member Materials Requirements

1. All written Member materials must follow the requirements in 5.10.3 and 5.10.4 above.
2. All written Member materials must be worded at or below a 6th grade reading level, unless otherwise approved in writing by the State.
3. All written Member materials shall be clearly legible with a minimum font size of 12 point.
4. All written Member material must be available in alternative formats, through the provision of auxiliary aids and services and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities. All Members must be informed of (1) how to request auxiliary aids and services; (2) that information is available in alternative formats at no cost and (3) how to access those formats.
5. All written Member materials must be printed with the assurance of non-discrimination.
6. All written Member materials shall be available in English and shall be translated and available in Spanish and any additional Prevalent Non-English Language.
7. The CONTRACTOR(S) is responsible for ensuring the translation is accurate and culturally appropriate.
8. With the request for approval, the CONTRACTOR(S) shall submit a certification to the State that the translation of the information into the different languages has been reviewed by a qualified individual for accuracy, and that the materials are available in each Prevalent Non-English Language. See Section 5.10.3 for approval timeframes.
9. All written Member materials shall notify Members that oral interpretation is available for any language at no expense to the Member and instructions for accessing oral interpretation.
10. A written notice of termination of a contracted Provider, within fifteen (15) calendar days from issuance of the termination notice, must be sent to each Member who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider.

### Member Enrollment Material Requirements

1. The CONTRACTOR(S) shall provide information for approval to the State and then the CONTRACTOR(S) will print information to be included with the welcome packet per State printing specifications for Members and potential Members in accordance with 42 CFR § 438.10(e) that includes the following:
2. Authorization requirements and how to obtain an authorization
3. Populations which are subject to mandatory managed enrollment
4. Service area of the CONTRACTOR(S)
5. Covered Services (including those covered by the State) and non-Covered Services
6. Provider Directory and formulary (this information will posted on the website and printed versions to be provided upon request within five [5] business days)
7. Network adequacy/access
8. Service Coordination responsibilities of the CONTRACTOR(S)
9. To the extent available, CONTRACTOR(S)’ quality and performance indicators including Member satisfaction
10. Email website location for Member Handbook
11. Information on how to request paper versions of Member materials
12. Notification to all Members of their right to request and obtain Member Handbook information at least once a year
13. Notification to all Members, at the time of enrollment, of the Member’s rights to change Providers or disenroll for cause
14. Listing of Value Added Benefits
15. Rights and responsibilities form, for those Members enrolling for HCBS services.
16. CONTRACTOR(S) must provide enrollment materials to all Members within ten (10) days of initial notification of enrollment.
17. Within the enrollment materials, the CONTRACTOR(S) shall provide a link to the online location of the State approved Member Handbook and other written materials with information on how to access services, to all Members. Paper versions of the Member Handbook will be mailed to Members within five (5) business days upon request.

### Member Handbook Requirements

1. When there are program changes, notification will be provided to the affected Members at least thirty (30) calendar days before implementation.
2. The Member Handbook and any updates shall be submitted to the State for approval.
3. Annually, the CONTRACTOR(S) shall summarize and submit to the State all Member Handbook changes by noting the pages changed and a brief description of the content changed. The CONTRACTOR(S) shall also submit a “clean” current electronic copy of the Member Handbook each year.
4. The electronic version of the Member Handbook shall be contained within one electronic file (rather than separate files for each chapter) for ease of searching and printing of the handbook.
5. The content of the Member Handbook must include the following:
6. A table of contents.
7. A glossary, where all CONTRACTOR(S) will use the State definitions for managed care terminology, including the terminology specified at 42 CFR § 438.10(c)(4)(i).
8. Online location of the provider directory, and features of the Provider Directory. Instructions on how to request a paper copy of the Provider Directory.
9. Appointment procedures.
10. Availability upon request any physician incentive plans in place as set forth in 42 CFR § 438.3(i).
11. A description of all available Covered Services, any Value Added Benefits, an explanation of any service limitations, or exclusions from coverage and a notice stating that the CONTRACTOR(S) will be liable only for those services authorized by the CONTRACTOR(S).
12. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency, including how to access the CONTRACTOR(S)’ twenty-four (24) hour toll-free number. Information should also distinguish between an emergency using the prudent layperson standard, emergent care, and Urgent Care. In a life-threatening situation, the Member Handbook should instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 9-1-1. The CONTRACTOR(S) shall not require the Member to call the CONTRACTOR(S) or PCP prior to going to the Emergency Room for Prior Authorization in accordance with section 1932(b)(2) of the SSA.
13. Description to the extent to which after-hours care is provided.
14. How to obtain emergency transportation and medically necessary transportation.
15. How to obtain Behavioral Health services.
16. How to obtain Value Added Benefits.
17. Information regarding out-of-county and out-of-state moves.
18. Informing the Member that if he or she has a worker’s compensation claim, or a pending personal injury or medical malpractice law suit, or has been involved in an auto accident, to immediately contact the KDHE-DHCF Medicaid Unit, TPL Manager.
19. Contributions the Member can make toward his or her own health, Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CONTRACTOR(S) or the State.
20. The CONTRACTOR(S)’ policy regarding copayments and charges to Members. Any cost sharing imposed on Medicaid and CHIP Members is in accordance with 42 CFR § 447.50 through 42 § 447.56.
21. The CONTRACTOR(S)’ procedures for notifying Members about terminations and/or changes in benefits, services or delivery dates.
22. Information regarding Advance Directives in accordance with 42 CFR § 438.3(j), including a description of State law as found in K.S.A. 65-28,101 and supporting documentation as specified in Section 5.10.2.
23. Benefits provided by the CONTRACTOR(S).

In the case of a counseling or referral service that the CONTRACTOR(S) does not cover because of moral or religious objections, the CONTRACTOR(S) must inform Members that the service is not covered by the CONTRACTOR(S). The CONTRACTOR(S) must inform Members how they can obtain information from the State about how to access these non‑Covered Services.

The amount, duration, and scope of benefits available under the CONTRACT in sufficient detail to ensure that Members understand the benefits to which they are entitled.

Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member’s PCP.

The extent to which, and how, after-hours and emergency coverage are provided, including: what constitutes an emergency medical condition and emergency services with reference to the definitions in 42 CFR § 438.114(a); Definition of post-stabilization services and the CONTRACTOR(S)’ responsibility for coverage; and locations which can provide emergency and post-stabilization services. Any restrictions on the Member’s freedom of choice among Participating Providers.

A list of services not covered by the CONTRACTOR(S) but covered by the State, see Attachment C — Services.

1. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from Non-Participating Providers. This includes an explanation that the CONTRACTOR(S) cannot require a Member to obtain a referral before choosing a family planning Provider.
2. Member rights and responsibilities, including the elements specified in 42 CFR § 438.100.
3. The process of selecting and changing the Member’s PCP. Member’s rights to change Providers or disenroll for cause.
4. Grievance, Reconsideration, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 CFR § 438 subpart F, in a State-developed or State approved description, see Attachment D. Such information must include: the right to file grievances, reconsiderations and appeals; the requirements and timeframes for filing a grievance or appeal; the availability of assistance in the filing process; the right to request a State Fair Hearing after the CONTRACTOR(S) has made a determination on a Member’s appeal which is adverse to the Member; the fact that, when requested by the Member, benefits that the CONTRACTOR(S) seeks to reduce or terminate will continue if the Member files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the Member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the Member.
5. How to access auxiliary aids and services, including additional information in in alternative formats or languages.
6. The toll-free telephone number for Member services, medical management, and any other unit providing services directly to Members.
7. Information on how to report suspected Fraud or Abuse.
8. Any other content required by the State.

NOTE: Some of this information may be included as inserts to the handbook. The CONTRACTOR(S) shall submit the Member Handbook to the State for approval prior to printing for distribution to Members. The CONTRACTOR(S) shall make modifications in handbook language if requested by the State.

### Provider Directory

1. The CONTRACTOR shall develop and maintain a Provider Directory, which shall be made available to all Members in the formats specified in this section and in accordance with 42 CFR § 438.10(h). The directory attributes specified in paragraph B of this section must be present in the directories for each of the Provider types covered under the CONTRACT, including but not limited to the following:
2. Physicians, including specialists
3. Vision
4. Dental
5. Hospitals
6. Pharmacies
7. Behavioral Health Providers
8. LTSS Providers
9. The following types of information are required elements for each Participating Provider listing within the Provider Directory. If this information is not available, the element must be listed in the directory with an indication that the details are unavailable:
10. Complete name
11. Address for all office locations, including street, city, county, and zip code
12. Phone number, including TTY phone line
13. Provider type
14. Specialty/services provided
15. Ages served
16. Group affiliations (i.e. affiliations through which the Participating Provider delivers services
17. Hours of operation
18. After hours contact information
19. Website URL
20. Whether the Participating Provider will accept new Members.
21. Cultural and linguistic capabilities, including languages spoken (e.g., Spanish, ASL, etc.) by the Participating Provider or a skilled medical interpreter at the Participating Provider’s office, and whether the Participating Provider has completed cultural competency training.
22. Whether the Participating Provider’s office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
23. Link to an interactive map with directions available.
24. The following types of information are optional elements for each Participating Provider listing within the Provider Directory and represent elements the State believes may increase Member choice of Provider:
25. Customer rating
26. Insurance plans accepted
27. Licensure/accreditation status
28. Service area listing
29. Special needs accommodations available
30. Whether public transportation is available in the service area
31. The text of the directories shall be in the format approved by the State. The Provider information used to populate the Provider Directories shall be submitted in a format specified by the State.
32. Within ten (10) calendar days of the member enrollment notification, the CONTRACTOR(S) shall notify the Member within the enrollment packet of the availability of the online Provider Directory and how to access the online Provider Directory, including a website address that takes the Member directly to the online Provider Directory. The notice shall also notify the Member of his/her right to request a hard copy of the Provider Directory and instructions for doing so, including the telephone number of the Member services information line. Annually thereafter, the CONTRACTOR(S) shall notify Members of their right to request a hard copy of the Provider Directories and instructions for doing so.
33. The CONTRACTOR(S) shall post the Provider Directory on the CONTRACTOR(S)’ website according to the following specifications:
34. The online version of the Provider Directory shall be searchable according to the required elements in paragraph B of this section; searchable by user information, to include at a minimum user address and distance from user location; accessible by users with special needs; and available to print, download, and email.
35. The online version of the Provider Directory shall be updated no later than thirty (30) calendar days after the CONTRACTOR(S) receives updated Provider information. All updates shall by implemented by the fifth (5th) calendar day of each month.
36. The online Provider Directory shall contain a disclaimer that the online Provider Directories are updated more frequently than the printed directory.
37. The following features of the electronic Provider Directory are optional:

A customizable directory listing based upon user specifications which could be downloaded.

Ability to compare multiple Participating Providers’ information at one time through user filter selections.

Ability for directory users to report incorrect Participating Provider listing information.

1. Upon request, Members shall receive a hard copy of the Provider Directory free of charge. The directory shall be mailed to Members within five (5) business days of the request. Members receiving a hard copy of the Provider Directory shall be advised that the CONTRACTOR(S)’ network may have changed since the directories were printed, and how to access current information regarding the CONTRACTOR(S)’ Participating Providers. The hard copy of the Provider Directories shall be updated at least monthly and all updates shall be implemented by the fifth (5th) calendar day of each month.
2. Upon request, the CONTRACTOR shall provide information on the participation status of any Provider and the means for obtaining more information about Participating Providers.

### Member Identification Cards

1. The CONTRACTOR(S) shall provide each Member an identification (ID) card within thirty (30) calendar days of the Member’s enrollment date.
2. The CONTRACTOR(S) shall re-issue a Member ID card within ten (10) calendar days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.
3. The Member ID cards shall not be overtly different in design from the ID card the CONTRACTOR(S) issues to its non-Medicaid Members.
4. The ID cards shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), comply with all State and Federal requirements and, at a minimum, include:
5. Phone numbers for the CONTRACTOR(S)’ toll-free Member services information line, nurse advice/nurse triage line, Pharmacy services call center, and any other key numbers
6. Descriptions of procedures to be followed for emergency services
7. The Member’s identification number
8. The Member’s name (first and last name and middle initial)
9. The Member’s date of birth
10. The Member’s effective date of Enrollment
11. The Member’s Copayment information for Covered Services
12. Phone numbers for vision and dental call centers
13. Toll-free phone number 24 hours a day/365 days a year to assist Members needing immediate assistance if it is different than the regular Customer Service toll-free number

## 5.10.10 Customer Service Center – Member Assistance

1. The CONTRACTOR(S) shall staff, operate, and maintain a Customer and Provider Service Center that is responsible for handling and responding to inquiries/correspondence received by telephone, fax, written, in person, or electronic means concerning the KanCare programs.
2. The CONTRACTOR(S) must operate a toll-free telephone service, for use by Members, potential Members, Providers, community-based service organizations, and other public or private agencies from 8:00am-5:00pm Central Time Monday through Friday, except for State-approved holidays. The CONTRACTOR(S) is responsible for providing sufficient in-bound toll-free lines to meet the performance standards outlined in Section 5.10.10.K below, including the following:
3. AVRS may be incorporated into the customer service plan. If an AVRS is used, separate queues must be available for English and Spanish calls.
4. The AVRS must be capable of providing specific information such as the fax number, hours of operation, etc., as well as allowing the caller to access a call center representative.
5. Provide an option in the initial menu to allow Members to contact a call center representative immediately.
6. Staffed with personnel who are knowledgeable about the CONTRACTOR(S)’ program, Covered Services and services covered outside the CONTRACT.
7. The Customer Service Center shall be a separate, identifiable, and centralized unit which is staffed with a sufficient number of trained staff to fulfill the functions of this unit. The staff answering calls must receive appropriate training including but not limited to: benefits and services, enrollment process, Grievance, Reconsiderations and Appeal processes, and logging and documenting calls.
8. The CONTRACTOR(S) will research, resolve and respond to all received inquiries made by Members and other parties.
9. The CONTRACTOR(S) will submit call center representative training plan, evaluation standards and tools to the State for approval ninety (90) days after CONTRACT award.
10. The CONTRACTOR(S) must provide language assistance and translation services necessary to ensure meaningful access at no cost to the LEP Members.
11. The CONTRACTOR(S) will have dedicated Member lines with sufficient staffing to meet CONTRACT standards.
12. The CONTRACTOR(S) must record all calls (inbound and outbound, including voicemails) for future retrieval that are received and handled within the call centers that handle calls directed to the CONTRACTOR(S)’ primary published Member Services
13. The CONTRACTOR(S) must provide a system to track and document all phone contacts, including incoming calls, outgoing calls, incoming email, outgoing email, web-based contacts and voice messages. The call tracking system shall have the capability to generate statistical reports regarding, for example, call volumes, length of time to answer, abandonment rates, length of the calls, nature of the contact and who answered the contact.
14. Call center report will be submitted to the State using State specifications and definitions. Reasons for the call shall be standardized between CONTRACTOR(S), and all statistics will be submitted as required by the State. Customer Service Center will maintain reporting systems with the capability to track all statistics necessary to address performance requirements listed in Section 5.10.10.K.
15. Customer Service Performance Standards - The CONTRACTOR(S) and their Subcontractors shall meet the following requirements for Customer Service:
16. 100% of incoming and outgoing calls must be documented and recorded.
17. 99% of calls will be answered by an individual or an electronic device without receiving a busy signal.
18. 80% of all calls will be answered in thirty (30) seconds or less. The average speed for answering calls will be thirty (30) seconds or less. The average abandonment rate will be four 4% or less.
19. 90% of calls answered will be resolved by the CONTRACTOR(S) during the initial contact.
20. 100% of received phone calls are recorded and the recordings maintained.
21. 100% of calls left on voice mail during or after working hours will be retrieved and returned within one (1) business day.
22. 95% of all inquiries shall be resolved within two (2) business days of receipt.
23. 98% of all inquiries shall be resolved within five (5) business days.
24. 100% of all inquiries shall be resolved within fifteen (15) business days.
25. 100% of all email inquiries will be answered within one (1) business day.
26. 90% quality monthly average for fully trained based upon the standards of the State approved CONTRACTOR(S) training plan.
27. 95% hold times equal to or less than one (1) minute for all inbound and outbound calls.
28. The data are used to monitor the above topics by obtaining information from the Members and Providers, resolving issues, identifying and addressing trends. If deficiencies are identified the CONTRACTOR(S) must report such findings to the State and perform corrective action until compliance is met.
29. The CONTRACTOR(S), through Customer Services, shall facilitate the development of Warm Transfers from Help Lines when the caller’s crisis cannot be addressed by the Help Lines. The State will consider options other than use of Warm Transfers for coordination of Help Line services that are proposed by the CONTRACTOR(S), as long as the other requirements of this section are met.
30. The CONTRACTOR(S) must provide a voicemail system that allows messages to be left during and after business hours.
31. The CONTRACTOR(S) must provide email customer service support with sufficient capacity to handle the incoming volume.
32. Toll-Free Fax Line: The CONTRACTOR(S) must provide a toll-free HIPAA compliant, secure fax system with sufficient capacity to handle the incoming volume.
33. Fax Service Performance Standards: The CONTRACTOR(S) shall meet the following requirements for fax line service:
34. 98% of the time, fax lines shall meet customer demand.
35. 95% of all inquiries shall be resolved within two (2) business days of receipt.
36. 98% of all inquiries shall be resolved within five (5) business days.
37. 100% of all inquiries shall be resolved within fifteen (15) business days.
38. The CONTRACTOR(S) shall have, maintain, and publish the availability of a HIPAA‑compliant email system to receive secure materials from Members and Providers electronically.
39. All fax, written communication and similar documents received shall be imaged/scanned into electronic files for documentation and retrieval purposes and stored using HIPAA-compliant methods.

### 5.10.11 Member Crisis Assistance

1. The CONTRACTOR(S) must operate a toll-free phone number twenty-four (24) hours a day/365 days a year to respond to Members needing immediate assistance.
2. The toll-free number must be published in the Member Handbook, the Member ID card and associated materials. The services of this Help Line shall include:
3. Telephone crisis intervention.
4. Risk assessment.
5. Referral and consultation to callers which may include caregivers, family members and other community agencies seeking assistance with Behavioral Health issues.
6. Kansas-specific information of community resources such as contact information to the Member’s local Regional Alcohol and Drug Assessment Center (RADAC), Social Detoxification unit, Certified Gambling Counselor or Mental Health Center shall be provided.
7. The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include:
8. Crisis responsiveness which includes twenty-four (24)-hours a day, seven (7) days a week, 365 days a year emergency treatment and first response, including, when appropriate, staff going to the individual for personal intervention, for any Member staff become aware of experiencing a crisis or other emergency.
9. Provision of or referral to psychiatric and other community services, when appropriate.
10. Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient treatment, crisis services, or other community treatment services.
11. Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services.
12. Follow up with any Member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.
13. In cases of discharge from inpatient care, the CONTRACTOR(S) will monitor Provider contact to Member following inpatient discharge with goals of offering and encouraging enrollee’s attendance at follow-up appointments. The timeframe begins with the day of the enrollee’s discharge. The CONTRACTOR(S) will ensure 85% of contact attempts will occur between 24 to 72 hours of discharge, 90% of contact attempts will occur within 1–7 days and 95% of contact attempts will occur within 1–10 days. The CONTRACTOR(S) will have protocols in place to review for compliance with this CONTRACT requirement.
14. CONTACTOR(S) agrees that there will be no requirements for pre-authorization for emergency services or treatment for a Behavioral Health crisis.

### 5.10.12 Member Rights and Protections

1. The CONTRACTOR(S) must have written policies regarding the Member rights specified in this section. The CONTRACTOR(S) must comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members. All Members shall be guaranteed the following rights and protection:
2. Information requirements. Each Member shall receive information in accordance with 42 CFR § 438.10.
3. Dignity and privacy. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
4. Receive information on available treatment options. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
5. Participate in decisions. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
6. Free from restraint or seclusion. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
7. Copy of medical records. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR § 164.
8. Free exercise of rights. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CONTRACTOR(S) and its Providers or the State treat the Member.
9. Compliance with Other State and Federal Laws and Regulations. CONTRACTOR(S) must comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Titles II and III of the ADA and section 1557 of the PPACA. CONTRACTOR(S) must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and other laws regarding privacy and confidentiality.
10. CONTRACTOR(S) must comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members.
11. The Member shall not be held liable for the CONTRACTOR(S)’ debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which the State does not pay the CONTRACTOR(S); not be held liable for Covered Services provided to the Member for which the State or the CONTRACTOR(S) do not pay the Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the CONTRACTOR(S) provided the services directly.
12. CONTRACTOR(S) will maintain a mechanism to gain Member input into their process and system of care. CONTRACTOR(S) shall create and maintain a Member Advisory Committee(s), which must be representative of the Membership being served, including LTSS and Behavioral Health Members.
13. A plan for the Member Advisory Committee(s) shall be submitted annually by the CONTRACTOR(S) and subject to approval by the State.
14. The plan shall include procedures for implementing the committee, including meeting at least quarterly, and details discussing how the CONTRACTOR(S) will ensure meaningful representation from all Member stakeholder groups.
15. The CONTRACTOR(S) shall submit an annual meeting calendar for the Member Advisory Committee to the State with dates, times and meeting places for each meeting. At least two (2) weeks prior to each meeting the CONTRACTOR(S) shall send a meeting agenda and other materials for the meeting to both committee members and the State.
16. Quarterly, the CONTRACTOR(S) shall submit a written report to KDHE-DHCF. The report shall contain information about meeting(s) held in the past quarter, how the CONTRACTOR(S) is addressing previous issues raised by the Member Advisory Committee, and who attended meetings. The CONTRACTOR(S) shall designate an employee to present this report and answer related questions to groups as identified by KDHE-DHCF.
17. CONTRACTOR(S) will be prohibited from restricting a Provider from advising or advocating on behalf of a Member.

## Grievances and Appeals

See Attachment D – Grievances, Reconsiderations, Appeals and State Fair Hearings for all requirements related to those processes.

## Program Integrity

### Program Integrity and Disclosure Requirements

1. The CONTRACTOR(S) and any Subcontractors with responsibility for coverage of services and payment of claims must establish arrangements or procedures that include, at a minimum the elements required in 42 CFR § 438.608(a)(1), specifically:
2. Written policies, procedures, and standards of conduct that articulate the CONTRACTOR(S)’ commitment to comply with all applicable requirements and standards under the CONTRACT, and all applicable Federal and State laws.
3. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the CONTRACT and who reports directly to the CEO and the board of directors.
4. The establishment of a regulatory compliance committee on the Board of Directors and at the senior management level charged with overseeing the CONTRACTOR(S)’ compliance program and its compliance with the requirements under the CONTRACT.
5. A system for training and education for the compliance officer, the CONTRACTOR(S)’ senior management, and the CONTRACTOR(S)’ employees for the Federal and State standards under the CONTRACT.
6. Effective lines of communication between the compliance officer and the CONTRACTOR(S)’ employees.
7. Enforcement of standards through well-publicized disciplinary guidelines.
8. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the CONTRACT.
9. CONTRACTOR(S) shall coordinate any and all program integrity efforts with KDHE-DHCF personnel and Kansas’ Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General’s Office. For LTSS and Behavioral Health service program integrity issues, coordination is also required with KDADS. At a minimum, CONTRACTOR(S) shall:
10. Meet monthly, and as required, with KDHE-DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of Fraud, as well as all recoupment actions taken against Providers.
11. Provide any and all documentation or information upon request to KDHE-DHCF, MFCU, CMS and its CONTRACTOR(S), or U.S. Health and Human Services’ (HHS) Office of the Inspector General (OIG) related to any aspect of this CONTRACT, including but not limited to policies, procedures, subcontracts, Provider agreements, claims data, Encounter Data, and reports on recoupment actions and receivables.
12. Per 42 CFR § 438.608(a)(7), report within two (2) business days to the KDHE-DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of Fraud, Waste, or Abuse by any Participating Provider or Non-Participating Provider. If the CONTRACTOR(S) fails to report any suspected Fraud, Waste or Abuse, KDHE-DHCF may invoke any penalties allowed under this CONTRACT including, but not limited to, suspension of payments or termination of the CONTRACT. Furthermore, the enforcement of penalties under the CONTRACT shall not be construed to bar other legal or equitable remedies which may be available to the KDHE-DHCF or MFCU for noncompliance with this section.
13. Provide KDHE-DHCF with a quarterly update of investigative activity, including corrective actions taken.
14. Provide KDHE-DHCF an annual Program Integrity work plan which outlines the CONTRACTOR(S) Program Integrity/Fraud Waste Abuse focus for the coming year.
15. Hire and maintain a staff person in Kansas whose duties shall be composed at least ninety (90%) of the time in the oversight and management of the program integrity efforts required under this CONTRACT. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR(S) is sufficient to meet the requirements of the KDHE-DHCF. The duties shall include, but not be limited to the following:

Oversight of the program integrity function under this CONTRACT.

Liaison with the State in all matters regarding program integrity.

Development and operations of a Fraud control program within the CONTRACTOR(S) claims payment system.

Liaison with Kansas’ MFCU.

Assure coordination of efforts with KDHE-DHCF and other agencies concerning program integrity issues.

1. Hire additional qualified staff to assist the Program Integrity Manager as appropriate based on the number of reviews/audits and investigations occurring.
2. The CONTRACTOR(S) shall ensure that all Participating Providers are enrolled with KDHE-DHCF as Medicaid Providers consistent with the Provider disclosure, screening and enrollment requirements of 42 CFR § Part 455, subparts B and E as incorporated in 42 CFR § 438.608(b) prior to executing a Provider agreement. Prior to paying claims to a Non-Participating Provider that is not enrolled with Kansas Medicaid, the CONTRACTOR(S) will, at a minimum, verify licensure and perform all Federal database checks as specified at 42 CFR § 455.436 on all Owners and managing employees.
3. The CONTRACTOR(S) shall diligently safeguard against the potential for, and promptly investigate reports of, suspected Fraud and Abuse by employees, Subcontractors, Providers, and others with whom the CONTRACTOR(S) does business. The CONTRACTOR(S) shall provide the State with its policies and procedures on handling issues of suspected Fraud and Abuse.
4. The CONTRACTOR(S) shall comply with all Federal and State Laws and Regulations related to Program Integrity and Disclosure Requirements. This includes any future Laws and Regulations that may be required as well as current Laws and Regulations.
5. The State, or any agent including the State’s Fiscal Agent or other CONTRACTOR, has the right to review, audit, and recover from Participating Providers. CONTRACTOR(S) and Subcontractors have a duty to cooperate with reviews and audits and must respond to State requests.
6. The CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(3) by promptly reporting to KDHE-DHCF any information received about changes to a Member’s circumstances that may affect the Member’s eligibility, including changes in the Member’s residence, the death of the Member, or other information specified by KDHE-DHCF.
7. CONTRACTOR(S) shall notify the State, on a monthly basis, as to any adverse action that has been taken against a Participating Provider’s participation in the program as specified in Adverse Action Report. The CONTRACTOR(S) shall report CONTRACTOR(S) and all Subcontractor Fraud and Abuse information on the schedule identified by and in the report template format prescribed by the State. In addition, the CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(4) by notifying KDHE-DHCF when the CONTRACTOR(S) receives information about a change in the Participating Provider’s circumstances that may affect the Participating Provider’s eligibility to participate in KanCare, including the termination of the Provider agreement with the CONTRACTOR(S).
8. Terminated Providers: CONTRACTOR(S) shall terminate Provider agreements with any Participating Provider whose Medicaid Provider Agreement has been terminated for cause by the State. Such Provider agreement termination shall be effective on the date specified within the notification from the State. CONTRACTOR(S) shall provide written notice of the Participating Provider termination to the Members assigned to such Provider at least ten (10) calendar days prior to the effective Provider agreement termination date and work to ensure any Member assigned to such Participating Provider are transitioned to another Participating Provider. CONTRACTOR(S) shall not enter into a Provider agreement nor pay a Non-Participating Provider terminated for cause by the State. Federal Financial Participation (FFP) is not available for amounts expended for Providers excluded by Medicare, Medicaid or CHIP, except for emergency services. In addition, CONTRACTOR(S)’ Subcontractors, and Members of CONTRACTOR(S)’ or Subcontractor’s Participating Providers are prohibited from employing or contracting with persons or entities that State has terminated from participation in the Kansas Medicaid program.
9. Inactivated Providers: CONTRACTOR(S) shall terminate Participating Provider contracts with any Participating Provider whose Medicaid Provider Agreement has been inactivated by the State. Such Participating Provider contract termination shall be effective on the date of inactivation by the State. CONTRACTOR(S) is not prohibited from entering into a single case agreement or other arrangement for Non- Participating Provider payment for such Providers.
10. CONTRACTOR(S) shall conduct an annual risk assessment of both CONTRACTOR(S)’ and each Subcontractors’ Fraud and Abuse/program integrity procedures (for those Subcontractors that are delegated to adjudicate claims on behalf of the CONTRACTOR(S), such as dental, vision, Pharmacy or transportation). The assessment shall include a listing of the top five (5) vulnerable areas and outline action to mitigate risks in each area. The assessment shall be provided to the State within thirty (30) days of its completion each year.
11. CONTRACTOR(S) shall be entitled to retain overpayment recoveries, including overpayments due to Fraud, Waste or Abuse that were first identified by the CONTRACTOR(S).
12. CONTRACTOR(S) shall, when directed by KDHE-DHCF, recover established overpayments made to a Provider by the State for performance or non-performance of activities not governed by this CONTRACT. When funds are recovered, CONTRACTOR(S) shall promptly notify KDHE-DHCF of any amount recovered and, as directed by KDHE-DHCF, CONTRACTOR(S) will immediately provide the amount recovered to KDHE-DHCF, or KDHE-DHCF will withhold the amount recovered from a payment otherwise owed to CONTRACTOR(S). In the event the overpayment is not recoverable, CONTRACTOR(S) shall promptly notify KDHE- DHCF and provide an explanation as to the reason the overpayment is not collectible.
13. KDHE-DHCF and any agent, including the State’s Fiscal Agent or other CONTRACTOR not a KanCare MCO, may discover and identify an overpayment to be recovered from a Participating or non-Participating Provider that was made by a CONTRACTOR(S), and the CONTRACTOR(S) shall be entitled to retain overpayment recoveries, including overpayments due to Fraud, Waste, or Abuse, that were first identified by the CONTRACTOR(S). CONTRACTOR(S) are not entitled to any recovery under this section when KDHE-DHCF and any agent, including the State’s Fiscal Agent or other agent, identifies and pursues overpayments, false claims, or fraudulent claims paid by the CONTRACTOR(S) to a Provider.
14. CONTRACTOR(S) shall require Participating Providers and Non-Participating Providers to report overpayments and specify the reason for the overpayment in writing. The overpayment shall be returned to the CONTRACTOR(S) within sixty (60) calendar days after the date on which the payment was identified.
15. The CONTRACTOR(S) shall comply with 42 CFR § 438.608(c)(3) by reporting to KDHE-DHCF, within sixty (60) calendar days of identification, capitation payments or other payment in excess of amounts specified in the CONTRACT.
16. CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(2) by promptly reporting all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to KDHE-DHCF.
17. The annual report on CONTRACTOR(S)’ recoveries and any information or documentation related to recoveries that were retained by the CONTRACTOR(S) or the State will be used by the State for purposes of developing Actuarially Sound Capitation Rates.
18. The CONTRACTOR(S) shall have in place a method to verify, on a regular basis, whether services reimbursed by the CONTRACTOR(S) were actually furnished to Members as billed by Participating Providers.
19. The CONTRACTOR(S) and any Subcontractors shall comply with 42 CFR § 455.23 by suspending all payments to a Provider after KDHE-DHCF determines that there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless KDHE-DHCF has identified in writing a good cause reason for not suspending payments or to suspend payments only in part.
20. CONTRACTOR(S) or Subcontractor(s) shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR § 455.23(b) and maintain the suspension for the durational period set forth in 42 CFR § 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 CFR § 455.23(g).
21. CONTRACTOR(S) and Subcontractor(s) shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR § 455.23(g).
22. CONTRACTOR(S) shall report Ownership and control information in accordance with 42 CFR § 438.608(c)(2):
23. The CONTRACTOR(S) shall disclose the following:

The name and address of any person (individual or corporation) with an Ownership or control interest in the CONTRACTOR(S). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

The date of birth and Social Security Number (in the case of an individual).

Other tax identification number (in the case of a corporation) with an Ownership or control interest in the CONTRACTOR(S) or in any Subcontractor in which the CONTRACTOR(S) has a five 5% or more interest.

Whether the person (individual or corporation) with an Ownership or control interest in the CONTRACTOR(S) is related to another person with Ownership or control interest in the CONTRACTOR(S) as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an Ownership or control interest in any Subcontractor in which the disclosing entity has a 5% or more interest is related to another person with Ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

The name of any other disclosing entity (or Fiscal Agent or CONTRACTOR) in which the Owner of the disclosing entity (or Fiscal Agent or CONTRACTOR) has an Ownership or control interest.

The name, address, date of birth, the Social Security Number of any managing employee of the disclosing entity (or Fiscal Agent or managed care entity).

1. Disclosures from the CONTRACTOR(S) are due:

Upon the CONTRACTOR(S) submitting the proposal in accordance with the State’s procurement process.

Upon the CONTRACTOR(S) executing a CONTRACT with the State.

Upon renewal or extension of the CONTRACT.

Within thirty-five (35) calendar days after any change in Ownership of the CONTRACTOR(S).

All disclosures must be provided to KDHE-DHCF.

FFP is not available in payments made to a disclosing entity that fails to disclose Ownership or control information as required by law.

1. Pursuant to 42 CFR § 455.106, upon execution of the CONTRACT and prior to renewal of the CONTRACT, or at any time upon written request by KDHE-DHCF, the CONTRACTOR(S) must disclose to KDHE-DHCF the identity of any person who:
2. Has Ownership or control interest in the CONTRACTOR(S), or is an agent or managing employee of the CONTRACTOR(S).
3. Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or CHIP since the inception of those programs.
4. The CONTRACTOR(S) shall implement in its Provider enrollment processes the obligation of Providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). CONTRACTOR(S) shall forward such disclosures to KDHE-DHCF. CONTRACTOR(S) shall abide by any direction provided to the CONTRACTOR(S) by KDHE-DHCF, pursuant to 42 CFR § 1002.3, on whether or not to permit the applicant to be a Participating Provider. Specifically, the CONTRACTOR(S) shall not permit the Provider to become a Participating Provider if KDHE-DHCF or the CONTRACTOR(S) determines that any person who has Ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or CHIP, or if KDHE-DHCF or the CONTRACTOR(S) determine that the Provider did not fully and accurately make any disclosure required pursuant to 42 CFR §1001.1001(a)(1).
5. Prohibited Relationships 42 CFR § 438.610:
6. The CONTRACTOR(S) and Subcontractor may not knowingly have a relationship with the following:

An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of an individual or entity described in Section 5.12.1.R.1.a.

1. “Relationship”, for purposes of prohibited affiliations, is defined as follows:

A director, officer, or partner of the CONTRACTOR(S) or Subcontractor.

A Subcontractor of the CONTRACTOR(S) or Subcontractor.

A person with beneficial Ownership of 5% or more of the CONTRACTOR(S)’ or Subcontractor’s equity.

A Participating Provider or person with an employment, consulting or other arrangement with the CONTRACTOR(S) or Subcontractor for the provision of items and services that are significant and material to the CONTRACTOR(S)’ or Subcontractor’s obligation under its CONTRACT with the State.

1. The CONTRACTOR(S) or Subcontractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the SSA.
2. The CONTRACTOR(S) must provide written disclosures of any prohibited affiliation under 42 CFR § 438.610.
3. Any Participating Provider or Provider entity, CONTRACTOR(S), or Subcontractor, that receives or makes $5 million in annual payments from KDHE-DHCF, must comply with section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6) as a condition of receiving payment. The $5 million amount will be based on paid claims, net of any adjustments to those claims. It will be the responsibility of Providers or Provider entities, CONTRACTOR(S) or Subcontractor to make the determination as to whether they meet the $5 million threshold. To comply with Section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6), the CONTRACTOR(S) must ensure that it has implemented all of the following requirements:

Must establish written policies that provide detailed information about the Federal laws identified in Section 1902(a)(68) of the SSA and any State laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws.

In addition to the detailed information regarding the Federal and State laws, the written policies must contain detailed information regarding the CONTRACTOR(S) policies and procedures to detect and prevent Fraud, Waste, or Abuse in Federal health care programs, including the Medicare and Medicare Advantage Programs.

The CONTRACTOR(S) must provide a copy of its written policies to all of its employees, contractors and agents of the vendor.

If the CONTRACTOR(S) maintains an employee handbook, the CONTRACTOR(S) must include in its employee handbook a specific discussion of the Federal and State laws described in its written policies, the CONTRACTOR(S)’ policies and procedures for detecting and preventing Fraud, Waste, or Abuse and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging Fraud, Waste, or Abuse in a Federal health care program, including the Medicare and KDHE-DHCF Programs, to the CONTRACTOR(S) or Provider or to the appropriate authorities.

1. Cost Recovery and Cost Avoidance Tracking and Reporting. The CONTRACTOR(S) must submit a quarterly payment integrity report to KDHE-DHCF detailing, for the reporting period, the dollar amounts cost avoided through front end edits and other cost avoidance efforts, and the dollar amounts identified and recovered through Fraud, Waste, or Abuse detection efforts. These reports must be in a format approved by KDHE-DHCF.
2. Other Requirements:

The CONTRACTOR(S) will use the unique identifier provided by the State’s Fiscal Agent for each individual Participating Provider.

The CONTRACTOR(S) shall report Fraud and Abuse information to KDHE-DHCF quarterly. The report will include the information as indicated on the report template approved by KDHE-DHCF.

The CONTRACTOR(S) shall document that safeguards at least equal to Federal safeguards (at 41 USC 423, section 27) are in place.

The CONTRACTOR(S) and Subcontractor shall conduct program integrity data analytics specific to Kansas data.

Denial or Termination of CONTRACT:

KDHE-DHCF may refuse to enter into or renew a CONTRACT with the CONTRACTOR(S) if any person who has an Ownership or control interest in the CONTRACTOR(S), or who is an agent or managing employee of the CONTRACTOR(S), has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or CHIP.

KDHE-DHCF may refuse to enter into or may terminate the CONTRACT(S) if it determines that the CONTRACTOR(S) did not fully and accurately make any disclosure required under this section.

### Member Fraud and Abuse

CONTRACTOR(S) shall notify the State of Members suspected of participating in fraudulent or abusive activities. Notification must be in written format with supporting documentation attached. The Members may be identified through UM, chart review, or by referral from Participating Providers. The CONTRACTOR(S) shall report to the State suspected fraudulent activities as directed by State policy or regulation.

The CONTRACTOR(S) is expected to provide Member education in an attempt to correct abusive behavior. Abusive behavior may include, but is not limited to:

1. Concurrently obtaining services from two or more Providers of the same specialty, not in the same group practice, with no referrals.
2. Using two or more emergency facilities for non-emergent diagnosis.
3. Concurrently using two or more prescribing physicians to obtain drugs from the same therapeutic class of medication.
4. Two or more occurrences of having Prescriptions for the same therapeutic class of medication filled two (2) or more times on the same or subsequent day by the same or different Providers.
5. Concurrently using two (2) or more pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer’s maximum recommended dosage as approved by the Food and Drug Administration.
6. Report of Member using the medical card to purchase drugs on a forged prescription.
7. Report of Member loaning a card to another individual to obtain Medicaid reimbursed services.
8. Consistently seeking/obtaining medical services which are not supported by diagnosis or medical records/documentation.
9. On request or recommendation of State Legal or KDHE-DHCF for cause.

## Financial Management

### Disclosure of Financial Records

1. The CONTRACTOR(S) shall establish and maintain an accounting system in accordance with generally accepted accounting principles, and the revenues and expenses properly applicable to this CONTRACT shall be readily ascertainable.
2. The CONTRACTOR(S) and any Subcontractors shall make available to the State, the State’s authorized agents, and appropriate representatives of the HHS, any financial records of the CONTRACTOR(S) or Subcontractors which relate to the CONTRACTOR(S)’ capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this CONTRACT. Accounting procedures, policies and records shall be completely open to state and Federal audit at any time during the CONTRACT period and for ten (10) years thereafter.
3. All financial submissions shall be certified/signed by the CONTRACTOR(S)’ Chief Financial Officer (CFO) or CEO or an individual who has delegated authority to sign for, and who reports directly to, the CEO or CFO. The purpose of the certification statement is to attest that the information submitted in the reports is current, complete and accurate. The statement should include the CONTRACTOR(S) name, reporting period, preparer information and signatures.
4. The CONTRACTOR(S) shall file with the State all financial reports in a format and frequency as specified by the State.
5. The CONTRACTOR(S) shall provide a written assurance stating the required performance bond and restricted reserve account will be submitted not later than forty-five (45) days after CONTRACT signing.
6. The CONTRACTOR(S) shall provide an insolvency plan documenting arrangements made which protect its subscribers in the event of insolvency. The CONTRACTOR(S) must include provisions for dividing the cash reserves, capital and surplus requirements among Participating Providers in the event of insolvency. CONTRACTOR(S) shall hold harmless Members in the event of insolvency and your Participating Providers shall not charge Members any portion of the costs associated with the provision of services under this CONTRACT.
7. The CONTRACTOR(S)’statutory reporting and other reporting requirements shall solely reflect the results of the KanCare program.
8. The CONTRACTOR(S) shall provide a copy of each Letter of Credit held.
9. The CONTRACTOR(S) shall notify the State in writing of any person or corporation that has 5% or more Ownership or controlling interest in the entity. The CONTRACTOR(S) shall submit financial statements for all Owners with interest of 5% or greater.
10. CONTRACTOR(S) shall submit audited financial reports specific to the Medicaid CONTRACT on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards to be defined by the State in accordance with 42 CFR § 438.3(m).

### Payment to CONTRACTOR(S)

1. Actuarially Sound Capitation Rates: The State’s actuaries will calculate a blended statewide Actuarially Sound Capitation Rates per rate cell to cover all Medicaid eligible populations, services and regions in accordance with generally accepted actuarial principles and in conformance with 42 CFR § 438.3(c)(1)(ii), § 438.4, § 438.5, § 438.7, and any Federal guidance governing Actuarially Sound Capitation Rates for Medicaid managed care programs.
2. Risk Adjustment: The final Actuarially Sound Capitation Rates will be subject to a risk adjustment methodology that is developed, documented, and approved in accordance with 42 CFR § 438.5(g) and 42 CFR § 438.7(b)(5). The approved risk adjustment methodology will be applied in a budget neutral manner, as defined in 42 CFR § 438.5(a).
3. Amendment Process: Rates for succeeding CONTRACT years (January 1 through December 31) shall be set annually by the KDHE-DHCF and their actuaries. These rates shall be adjusted annually from the preceding year for inflation, trends, utilization, and policy changes and must be approved by CMS.
4. For purposes of developing Actuarially Sound Capitation Rates, the CONTRACTOR(S) shall submit validated Encounter Data and audited financial reports in accordance with 42 CFR § 438.5(c). The completion of a Medicaid Reporting Template in a format designed by the State and its actuaries is also required.
5. Monthly capitation payments calculated in accordance with the CONTRACT will be paid by the State and the CONTRACTOR(S) may only retain capitation payments for Medicaid eligible Members. CONTRACTOR(S) has sixty (60) days from the date in which the CONTRACTOR(S) discovers an overpayment to return such overpayment to the State or be subject to appropriate penalty.
6. Capitation payments made by the State to CONTRACTOR(S), including any amounts earned by the CONTRACTOR(S) under a withhold arrangement as defined in 42 CFR § 438.6(b)(3), constitute full and complete payment to CONTRACTOR(S) for all goods and services provided by CONTRACTOR(S) to the State for the time period covered by such capitation payments. The State may recover CONTRACTOR(S)’ monthly capitation payments if the Member is subsequently determined to be ineligible for the month in question when the CONTRACTOR(S) actually provided service. Consideration may be given in instances where the CONTRACTOR(S) has paid for services.
7. The CONTRACTOR(S) has the right to audit case mix information and the supporting medical records and to recommend adjustments/corrections to that data; however, the State retains ultimate authority in deciding whether to implement those adjustments. The CONTRACTOR(S) must request any adjustment affecting the case mix from the State no later than thirty (30) days prior to the rate effective date. The CONTRACTOR(S) will provide documentation and details relative to how it will audit case mix data.
8. In instances where enrollment is disputed between two CONTRACTOR(S), the State will be the final arbitrator of CONTRACTOR(S)’ membership and reserves the right to recover an inappropriate capitation payment. The State also reserves the right to recover other types of inappropriate capitation payments, including but not limited to untimely notice from the CONTRACTOR(S) to the Administrative Services CONTRACTOR(S) of a Member’s request to disenroll.
9. Any and all recoveries from risk corridor/quality measure calculations for withhold arrangements will be subtracted from the per member per month (PMPM) payment in the following month(s). If no further PMPM payments are due, the CONTRACTOR(S) will issue a check payable to KDHE-DHCF.
10. Medical Loss Ratio:
11. The CONTRACTOR(S) shall calculate and report an MLR consistent with the requirements specified in 42 CFR § 438.8 for the MLR reporting year. The CONTRACTOR(S) shall use the following key components in its MLR calculation as to be further detailed in the State’s MLR Reporting Template:

Numerator: Sum of the CONTRACTOR(S)’ incurred claims, activities that improve health care quality, and Fraud prevention activities. The expenditures for Fraud prevention activities shall not be included in the numerator until CMS adopts a standard for the private market at 45 CFR Part 158.

Denominator: The adjusted premium revenue, which is premium revenue less the CONTRACTOR(S)’ Federal, State, and local taxes and licensing and regulatory fees.

The CONTRACTOR(S) shall aggregate the data across rate cells under the CONTRACT for the MLR calculation.

The CONTRACTOR(S) may apply a credibility adjustment factor to the MLR if the MLR experience is deemed to be partially credible as specified in the credibility adjustment factors issued by CMS for the MLR reporting year.

1. The CONTRACTOR(S) shall submit the MLR report within eight (8) months of the close of the MLR Reporting Year as specified in Attachment H.
2. The State may require the CONTRACTOR(S) to pay a remittance to the State if the MLR under the CONTRACT for the MLR reporting year is less than 85%. If the remittance is required by the State, the amount of the remittance owed is the different between the CONTRACTOR(S)’ MLR for the MLR reporting year and the minimum MLR percentage of 85%. The remittance is due to the State within thirty (30) calendar days of notification from the State that a remittance is owed. The requirement to pay the remittance survives the termination of this CONTRACT.

## Claims Management

### Timely Claims Processing

The CONTRACTOR(S) may enter into any payment arrangement with Providers that adequately reimburses Providers for services and supports integrated, coordinated care, including shared saving arrangements to the extent that they do not conflict with Federal or State regulations. However, the CONTRACTOR(S) must pay all claims timely and accurately. The CONTRACTOR(S) is responsible for submitting information about services rendered and reimbursed in the HIPAA-required formats specified in the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions companion guides, the 837 Dental Services Claim and Encounter Transactions and National Council for Prescription Drug Programs (NCPDP) standards, all of which can be found under Publications, HIPAA Companion Guides, at this website: https://www.kmap-state-ks.us/.

CONTRACTOR(S) shall implement the claims processing requirements set out in Attachment I: KanCare Claims Processing Requirements.

1. A claim is defined below:
2. Claim means (i) a bill for services, (ii) a line item of service, or (ii) all services for one Member within a bill.
3. Clean claim means one that can be processed without obtaining additional information from the Provider of the service or from a third party. It does not include a claim from a Provider who is under investigation for Fraud or Abuse, or a claim under review for Medical Necessity.
4. The CONTRACTOR(S) shall meet the following payment requirements:
5. 100% of all clean claims including adjustments must be processed and paid or processed and denied within thirty (30) calendar days of receipt.
6. 99% of all non-clean claims including adjustments must be processed and paid or processed and denied within sixty (60) calendar days of receipt.
7. 100% of all claims including adjustments must be processed and paid or processed and denied within ninety (90) calendar days of receipt.
8. Abide by the specifications of the following:
9. The date of receipt is the date the CONTRACTOR(S) receives the claim, as indicated by its date stamp on the claim.
10. The CONTRACTOR(S) and each of their Subcontractors shall upon receipt identify each claim and its attachments, adjustment, and financial transaction with a unique Internal Control Number (ICN). Each CONTRACTOR(S) shall submit a description of their ICN structure including ICN descriptions for each of their subcontractors, and resubmit such description(s) whenever there is a change.

Note: The ICN is alphanumeric, has a maximum field length of sixteen (16) bytes and includes at a minimum the date of claim receipt. Additional identifiers could include the batch number, sequence of claim within the batch and an indicator of the type of claim submission.

1. The date of payment is the date of the check or other form of payment.
2. The CONTRACTOR(S) shall provide technical assistance to Providers for claims submission.
3. The CONTRACTOR(S) must track and report separately the number of submitted, paid and denied claims and adjustments each month.
4. Nursing Facilities
5. The CONTRACTOR(S) shall:

Pay at least the FFS rate to NF.

Edit claims and claims systems based on patient liability deductions.

When and as directed by KDHE-DHCF /KDADS, process recovery and recoupment of claims for quality care assessment delinquencies, and provide the amount recovered to KDHE-DHCF/KDADS.

Pay 90% of clean claims within fourteen (14) calendar days and 99.5% of clean claims within twenty-one (21) calendar days. The CONTRACTOR(S) will also provide technical assistance to nursing home Providers for claims submission.

1. Exception: The CONTRACTOR(S) and its Providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the subcontract.
2. Reports: The CONTRACTOR(S) shall report on claims payments as required in Attachment H – Reporting Requirements.
3. Successful CONTRACTOR(S) shall collaborate to provide consistent practices, such as on-line billing, for claims submission to simplify claims submission and ease administrative burdens for Providers in working with multiple CONTRACTORS.
4. CONTRACTOR(S) shall automatically reprocess claims when a CONTRACTOR(S) system issue has resulted in an incorrect processing of the claim. In those instances, CONTRACTOR(S) will not require Providers to resubmit claims or file appeals; and these claims will be exempted for timely filing purposes, and reported as such by CONTRACTOR(S).
5. CONTRACTOR(S) will adopt and implement standardized timely filing requirements, applying a one-hundred eighty (180) calendar filing limit for all claims for all services, and a 365 day limit for any correction or rebilling of a timely filed claim, unless the Provider agrees through their CONTRACT to an alternate timely filing timeframe.
6. CONTRACTOR(S) shall process Provider claim adjustments and corrected billings the same as other claims received.
7. CONTRACTOR(S) will be responsible for routing all electronic data interchange (EDI) and paper claims received by them to their Subcontractors as appropriate and ensuring that claims are tracked appropriately for timely claims processing.
8. CONTRACTOR(S) shall, when directed by KDHE-DHCF, recover established overpayments made to a Provider by the State for performance or non-performance of activities not governed by this CONTRACT. When funds are recovered, CONTRACTOR(S) shall promptly notify KDHE-DHCF of any amount recovered and, as directed by KDHE-DHCF, CONTRACTOR(S) will immediately provide the amount recovered to KDHE-DHCF, or KDHE-DHCF will withhold the amount recovered from a payment otherwise owed to the CONTRACTOR(S). In the event the overpayment is not recoverable, the CONTRACTOR(S) shall promptly notify KDHE-DHCF and provide an explanation as to the reason the overpayment is not collectable.
9. KDHE and any agent, including the State’s fiscal agent or other contractors not a KanCare MCO, may discover and identify an overpayment to be recovered from a KanCare Provider for an overpayment made by a CONTRACTOR(S) (KanCare MCO), and recovery will be the property of the State. CONTRACTOR(S) are not entitled to any recovery under this section when KDHE and any agent, including the State’s Fiscal Agent or other CONTRACTOR(S) not a KanCare MCO, identifies and pursues overpayments, false claims, or fraudulent claims paid by the CONTRACTOR(S) to a Provider.
10. Pursuant to requirements of 42 CFR § 438.3(s)(2) and (3), CONTRACTOR(S) must provide all claims information to the State on covered outpatient drugs administered to Members, if the CONTRACTOR(S) is responsible for coverage of such drugs, within forty-five (45) calendar days after the end of each quarterly rebate period. Pursuant to 42 CFR § 447.511(c), the State is required to provide utilization information for MCO covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to CMS. The CONTRACTOR(S) must ensure that claims from 340B pharmacies for products purchased through the 340B discount drug program are identified at the claim level and that this information is included on each Encounter Claim.

### Post-Pay Recovery, Third Party Liability, and Coordination of Benefits

1. Post-Pay Recovery and TPL: TPL refers to any individual, entity or program that may be liable for all or part of a Member’s health coverage. Under section 1902(a)(25) of the SSA, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid Member. The CONTRACTOR(S) shall also follow all Federal regulations and all State of Kansas statutes and regulations for TPL and medical Subrogation. The CONTRACTOR(S) shall have procedures in place to collect TPL funds when primary coverage is identified after payment has been made.
2. CONTRACTOR(S) must agree to take responsibility for identifying and pursuing TPL for its Members. The CONTRACTOR(S) must identify and coordinate with all third parties against whom Members may have a claim for payment or reimbursement for services. These third parties may include Medicare, any other group insurance, trustee, union, welfare, or employer organization, employee benefit organization including preferred Provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by state law. CONTRACTOR(S) shall have processes to identify Members newly eligible for Medicare or other payers and to recover Provider payments, as applicable, for services rendered for any period in which the Member was later found to have Medicare and/or other coverage. CONTRACTOR(S) shall have processes to coordinate among departments to educate Members regarding Medicare eligibility and/or have the ability to refer the Member to appropriate Medicare resources or experts.
3. Coordination of Benefits (COB):
4. Medicaid is secondary to all other third parties with the exception of Special Health Services, Vocational Rehabilitation, Indian Health Services and Crime Victim’s Compensation Funds. As capitated payments made to the CONTRACTOR(S) are from Medicaid funds, CONTRACTOR(S) would be secondary to all other third parties not listed above.
5. The State has adjusted the CONTRACTOR(S)’ capitation payment equal to the State’s TPL recoveries for Members. In lieu of this offset to Capitation Payments, CONTRACTOR(S) will retain its TPL recoveries.
6. CONTRACTOR(S) shall perform data matches with Medicare and with Private Health Insurance companies to ensure that it maintains a full and accurate list of primary insurance. CONTRACTOR(S) shall also participate in the Defense Enrollment Eligibility Reporting System (DEERS) data match and the Public Assistance Reporting Information System (PARIS) data match.
7. CONTRACTOR(S) must track its TPL cost avoidance and recovery for all Members and report this recovery amount to the State according to the format and schedule specified by the State in the Payment Integrity Report.
8. Data transfer of TPL information on any Member shall occur according to the format and schedule specified by the State.
9. The State shall transfer to the CONTRACTOR(S) any new TPL information for any Member that comes to their attention.
10. CONTRACTOR(S) will coordinate with the State to comply with any information requests regarding child support birth expenses within ten (10) business days
11. Claims for EPSDT, pregnancy care and prenatal care shall be paid at the time presented for payment by the Provider and CONTRACTOR(S) shall bill the responsible third party.
12. CONTRACTOR(S) will make available to Providers, through their website, all TPL information on file for Members.
13. CONTRACTOR(S) will follow Other Insurance (OI) and Medicare pricing rules as established by Kansas Medicaid policy.
14. CONTRACTOR(S) shall transfer to the State, in the form, frequency and manner prescribed by the State, valid and verified new TPL lead information for all Members.
15. CONTRACTOR(S) will participate in the Coordination of Benefits Agreement (COBA) Medicare crossover process. The CONTRACTOR(S) will accept and process Medicare crossover claims for all assigned Members and maintain HIPAA compliance and follow state COBA policy and process.
16. The State reserves the right to conduct a supplemental (come-behind) recovery program for TPL. Any TPL identified and recovered by the State more than six (6) months after the date of payment of a claim will be retained by the State.

### Encounter Data and Other Data Requirements

CONTRACTOR(S) shall collect service information in standardized formats approved by the State and must make all collected data available to the State after it is tested for accuracy, completeness, logic and consistency in accordance with 42 CFR § 438.242. It is the CONTRACTOR(S) responsibility to ensure their Subcontractors’ Encounter Data is built according to State specifications and accurately reflects actual claims adjudication prior to data for submission to the State including accurately identifying the Provider who delivers any services.

1. CONTRACTOR(S) shall certify data including, but not limited to, all documents specified by the State, enrollment information, Encounter Data, and other information contained in CONTRACTS, and proposals. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CONTRACTOR(S) must submit the certification concurrently with the certified data and documentation. Data must be certified by one of the following:
2. The CONTRACTOR(S)’ CEO.
3. The CONTRACTOR(S)’ CFO.
4. An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)’ CEO or CFO.

For additional information see Attachment J – Encounter Data and Other Data Requirements.

## Information Systems

### Health Information Technology and Health Information Exchange

1. HIT and HIE are two of the cornerstones of efforts in Kansas to improve the coordination and delivery of health care services. They are also central to Federal efforts under the PPACA to improve the quality and effectiveness of health care services.
2. HIT refers to electronic systems that make it possible for health care Providers to better manage patient care through secure use and sharing of health information. HIT includes the use of Electronic Health Records (EHRs) instead of paper medical records to maintain people's health information.
3. HIE refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.
4. KDHE-DHCF’s vision and strategy for implementing HIT initiatives is to pursue initiatives that encourage the adoption of certified EHR technology, promote health care quality and advance HIE capacity in Kansas. KDHE-DHCF’s mission for HIT in Kansas is to:
5. Transform health care in Kansas through the deployment, coordination, and use of HIT and HIE.
6. Currently, there are two Regional Health Information Organizations (HIOs) providing technology services in Kansas:
7. The Kansas Health Information Network (KHIN) is a collaborative, Provider-led HIO solution originally formed by the Kansas Medical Society (KMS) and the Kansas Hospital Association (KHA). Currently, KHIN has a number of planned community-based HIOs which provide core HIT functionality. These include the Wichita HIE, eHealth Align in Kansas City and the Rural Health Information Network.
8. The Lewis and Clark Health Information Exchange (LACIE) operates in Kansas and Missouri and participants range in size from small independent physician practices to large academic medical centers. Incorporated in 2009, LACIE has been exchanging data since 2010 between independent healthcare organizations and Providers.
9. Additionally, two health systems, the University of Kansas Medical Center and KanCare Network, also incorporate Telemedicine, medical consultation and other services beyond baseline EHR or HIE.
10. HIT/HIE Requirements for the MCO: CONTRACTOR(S) shall submit a plan to the State that details how it will use HIT and HIE to improve coordination and integration of care, promote prevention and Wellness, and improve quality through appropriate sharing of clinical and administrative data among Providers and to the State. This plan at a minimum will:
11. Demonstrate how the CONTRACTOR(S) will accept and utilize data from certified EHR technology.
12. Demonstrate how the CONTRACTOR(S) will promote meaningful use (as defined in the American Recovery and Reinvestment Act of 2009), APMs, and Merit-based Incentive Payment System (MIPS) of EHRs among its Participating Providers.
13. Utilize the HIE and EHR Data for reporting where appropriate.
14. CONTRACTOR(S) shall submit a preliminary plan as part of its proposal to the State that details how it will use HIT to improve coordination and integration of care, promote prevention and Wellness, interoperability and improve quality through appropriate sharing of clinical and administrative data among Providers and to the State. This plan, at a minimum, will:
15. Specify how the CONTRACTOR(S) will work within the framework outlined by KDHE-DHCF to facilitate electronic exchange of health information between Providers and the CONTRACTOR(S), and between the CONTRACTOR(S) and the State using standard based protocols.
16. Demonstrate how the CONTRACTOR(S) will work with Providers to assist in their acquisition and use of certified EHR technology in accordance with the Kansas State Medicaid HIT Plan (SMHP).
17. Demonstrate how the CONTRACTOR(S) will accept and use data from certified EHR technology.
18. Demonstrate how the CONTRACTOR(S) will assist Providers in developing registries of Members with Chronic Conditions to help improve Care Management.
19. Demonstrate how the CONTRACTOR(S) will use its HIT system to provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for any reason other than a loss of Medicaid eligibility.
20. Collect data on Member and Provider characteristics, as specified by the State and on services furnished to Members through an Encounter Data system and other methods as may be specified by the State.
21. Upon CONTRACT implementation, the CONTRACTOR(S) shall work with the State and other relevant CONTRACTOR(S) to develop a joint plan to move HIT and EHR forward in Kansas
22. CONTRACTOR(S) shall provide the following for Pharmacy services:
23. Operate and maintain a fully-functional PA system to support both automated and manual PA determinations and responses, at minimum, capable of:

Examining up to twenty-four (24) months of administrative data; for example, patient-specific Pharmacy, medical and Encounter Data from both FFS and CONTRACTOR(S) and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes but is not limited to Pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/denied clams, Provider, etc.).

Gathering and applying appropriate decision criteria needed to make an automated authorization or precertification decision.

Integrating with the Point of Sale (POS) claims processor and all corresponding processing applications and providing an automated decision during the POS transaction with the CONTRACTOR(S)’ POS system in accordance with NCPDP mandated response times with 95% of electronic PA system transactions completing in less than one (1) second.

Submitting PA requests electronically in HIPAA-compliant transaction formats and in the NCPDP D.0 format at no additional charge to the CONTRACTOR.

Providing a detailed reporting package.

Generating and distributing PA denial letters to Members and applicable health care Providers.

Communicating the decision clearly and quickly to the health care Provider as per State policy.

Updating internal records in adjudication/claims systems and call tracking systems in conjunction with claims adjudication.

Provide continuity of care contingencies consistent with State policies and guidelines for the drug specific standards as required upon the implementation of new Preferred Drug List (PDL) and PA programs.

Provide capability of exempting all medications prescribed for a Member with a specific disease state.

Provide capability to utilize a prescriber’s specialty code in rendering an automated PA determination.

1. Allow for low impact and quick turnaround maintenance of PDL and PA criteria through table-driven criteria as opposed to hard coded criteria.
2. Possesses documented experience in the Medicaid arena (5 or more Medicaid Clients) with a comprehensive library of effective criteria to leverage and expand the PA portfolio.
3. Provide documented administrative and drug savings through previous experience.
4. Provide measurable Outcomes for quality improvement reports.
5. Offer back-up system redundancy to provide for business continuity with uninterrupted twenty-four (24) hours a day, seven (7) days a week production support and service 365 days a year.
6. CONTRACTOR(S) must have an established technology platform that provides technology support, including demonstrated success in provision of web-based portals with appropriate security features that allow Providers to verify Member eligibility and submit claims for services rendered.
7. Provide the Provider community with the ability to automate the PA process through a HIPAA-compliant, web-based Provider portal which shall, at minimum, be capable of:
8. Minimizing the burden on the Provider community while driving appropriate utilization.
9. Supplying access to electronic health records to health care Providers via a secure login process.
10. Electronically and securely submit Pharmacy and non-Pharmacy PA requests for automated and manual review by examining up to twenty-four (24) months of administrative data; for example, Member-specific Pharmacy, medical and Encounter Claims and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes but is not limited to Pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/denied claims, Provider, etc.).
11. Provide authorized users with access to Members’:

Member profile information

Prescriber information

PA history

PA questions

Automated criteria check

Approval and Denial Outcomes

Ability to attach applicable medical record data to PA submissions

Ability to request reconsideration of denial Outcomes electronically

1. CONTRACTOR(S) shall operate and maintain a fully-functioning Electronic Visit Verification (EVV) System for HCBS claim submissions and Service Coordination. Specifically:
2. CONTRACTOR(S) shall utilize and comply with all terms of the State’s Contract procuring an EVV system.
3. The State would invite and carefully consider any proposed alternative to the State’s existing EVV system submitted by CONTRACTOR, in collaboration with other KanCare CONTRACTOR(S), if it is an accessible, outcome-effective and cost efficient alternative.
4. CONTRACTOR(S) shall ensure that the EVV system creates and makes available on at least a daily basis an electronic claims submission file for HCBS in the HIPAA 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR(S) for claims processing at the appropriate frequency.
5. CONTRACTOR(S) shall monitor and use information from the EVV system to verify that services are provided as specified in the PCSP and Plan of Service, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized Provider/worker so that the Member/consumer may immediately address service gaps, including late and missed visits. CONTRACTOR(S) shall monitor Covered Services anytime a Member is receiving services, including after the CONTRACTOR(S)’ regular business hours.

### Use of and Safeguarding Data

In addition to the provisions of Attachment J – Encounter Data and Other Data Requirements, CONTRACTOR(S) agrees to comply with the following:

1. CONTRACTOR(S) must meet all Federal requirements identified under HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act. It is the responsibility of CONTRACTOR(S) to ensure all subcontractors that have access to PHI comply with HIPAA and HITECH requirements.
2. Data Files: Data files and data contained therein shall be and remain the property of the State and shall be returned to the State by CONTRACTOR(S) upon the termination of this Agreement. State data shall not be utilized by CONTRACTOR(S) for any purpose other than that of rendering services to the State under this CONTRACT, nor shall State data or any part thereof be disclosed, sold, assigned, leased or otherwise disposed of to third parties by CONTRACTOR(S) unless there has been prior written State approval. The State shall have the right of access and use of any data files retained or created by CONTRACTOR(S) for systems operation under this CONTRACT.
3. Safeguarding Data: CONTRACTOR(S) shall establish and maintain at all times, reasonable safeguards against the destruction, loss or alteration of the program data and any other data in the possession of CONTRACTOR(S) necessary to the performance of operations under this CONTRACT.
4. Confidentiality of Data and Records:
5. CONTRACTOR(S) shall comply with 45 CFR § 205.50, and 42 CFR § Part 2, Safeguarding Information for the Financial Assistance and Social Service Program, 42 CFR § 431 Subpart F, as well as 41 USC 423 27. The CONTRACTOR(S) must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, 42 CFR § Part 2, etc.) and other laws regarding privacy and confidentiality. As deemed necessary, the State or its designated agent, and the Federal government shall be allowed access to this data. All information, except as noted above, as to personal facts and circumstances obtained by CONTRACTOR(S) shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the State and the written consent of the Member, or his/her attorney, or his/her responsible parent or guardian.
6. Data and information received by CONTRACTOR(S) and maintained in the CONTRACTOR(S)’ database shall be used only for health policy decisions and research. Persons or agencies making requests for data or information from the CONTRACTOR(S)’ database shall be directed to the State.
7. Appropriate administrative, technical, procedural and physical safeguards shall be established by CONTRACTOR(S) to protect the confidentiality of the data and to prevent unauthorized access to it. The State reserves the right to approve or disapprove of CONTRACTOR(S)’ security procedures.
8. Security of Facilities: CONTRACTOR(S) shall provide all reasonable security procedures at any place where services are performed by CONTRACTOR(S) under this CONTRACT. CONTRACTOR(S)’ personnel shall comply with the rules of the State with respect to access to State offices, data files and data.
9. Rights in Data and Disclosure of Information:

The State of Kansas operates under the Open Records Act. The State may duplicate, use or disclose in any manner and for any purpose whatsoever, all data, reports and documentation delivered to the State under this CONTRACT. This obligation is not subject to any limitation in any respect except as provided under State or Federal laws. CONTRACTOR(S) hereby grants to the State, a royalty-free, non-exclusive, and irrevocable license to publish, reproduce, deliver, and to authorize others to do so, all such data, reports and documentation.

It is recognized by the parties that certain information or financial data pertaining to CONTRACTOR(S) may be exempted from public disclosure under both State and Federal law. Such data, which CONTRACTOR(S) does not want disclosed, will be prominently identified by CONTRACTOR(S).

If the State receives a request for disclosure of such information which the CONTRACTOR(S) has marked as proprietary, the State as an accommodation to the CONTRACTOR(S), before releasing the same will give the CONTRACTOR(S) notice orally or in writing at least forty-eight (48) hours before the release, in order that the CONTRACTOR(S) may immediately seek any relief available to it under State or Federal law. Failure to give timely notice shall not be a basis for a cause of action against the State of Kansas, their employees, agents and representatives.

1. Notification and Discussion of Potential System Changes:

CONTRACTOR(S) shall notify the State of the following changes to systems within its span of control at least ninety (90) calendar days before the projected date of the change. If so directed by the State, the CONTRACTOR(S) shall discuss the proposed change with the applicable State staff and submit testing and implementation plans, where applicable. This includes:

Software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, Provider enrollment and data management.

Conversions of core transaction management systems.

New system implementations.

Infrastructure upgrade.

## Reporting and Data Collection

The State is implementing a new reporting and data collection strategy that will improve data integration and analytics capabilities by developing a data centric system that collects, integrates, and analyzes data from a variety of sources, including required self-reporting (outlined in Attachment H) across the full continuum of care. This approach will enable the State to project risk, enhance Service Coordination, mitigate service gaps and promote quality, access and efficiencies. The State anticipates that over time the number of MCO generated reports will decrease.

1. CONTRACTOR(S) shall provide data elements and reports, including data and reports from Subcontractors, in a format and frequency determined by the State (see Attachment H) and perform ad hoc analysis and reporting as requested and within prescribed timeframes established by the State.
2. When ad-hoc data and/or reporting requests are made by the State, CONTRACTOR(S) shall affirm in writing their understanding of the request, the State-prescribed methodology to be used and the required timelines for submission. The CONTRACTOR(S) will be responsible for ensuring that data elements contained within their system(s) map appropriately to the State-defined data elements for inclusion in the State’s data warehouse.
3. CONTRACTOR(S) shall provide a description of their technical expertise for the team that supports data and reporting by describing their staffing model in this area, along with information about staffing capabilities, including job titles and brief job descriptions.
4. CONTRACTOR(S) is responsible for providing oversight and quality assurance of their Subcontractor(s)’ systems to ensure all required data complies with State requirements. The CONTRACTOR(S) remains solely responsible for meeting all reporting and data requirements set forth by the State. Issues discovered by the State will be communicated to the CONTRACTOR(S) for resolution; the State will not interact with Subcontractors to resolve any issues, answer questions or provide technical assistance; this is the responsibility of the CONTRACTOR(S). Ad-hoc queries issued by the State must be addressed by the CONTRACTOR(S) in the timeframes specified by the State and must include Subcontractor data where appropriate.
5. CONTRACTOR(S) shall provide flowchart(s) depicting how data enters their system(s), how it interacts and relates to other internal systems and how data is generated from the system(s) and exchanged with external trading partners. This includes interactions CONTRACTOR(S) has with any Subcontractors that provide EDI functions.
6. CONTRACTOR(S) shall demonstrate that quality control checkpoints are in place by submitting quality control procedures and processes that include tracking, trending, reporting, process improvement and monitoring of data submissions to include revisions and methodology to eliminate duplicate data. Submitted documentation must show that coding of data is consistent throughout all records and data sources. CONTRACTOR(S) must provide:
7. Description of change control processes for implementing change in data content and structure including feedback mechanisms to improve data accuracy, timeliness and completeness.
8. Documentation describing the tools and methodologies used to determine compliance with data submissions.
9. A flow chart and narrative description of data flows between internal systems and external organizations.
10. Documentation of employment of a technical staff with expertise to support all data and reporting functionality.
11. CONTRACTOR(S) must participate in all data validation activities required by the State. CONTRACTOR(S)’ data submissions, including data provided by Subcontractors, must meet adequacy requirements per State guidelines. Data must be validated for accuracy and completeness prior to submission. Report templates, along with process requirements for the submission of data and reports, will be detailed in the contracting process. On an ongoing basis, the State may require responses from the CONTRACTOR(S) regarding their data submissions, including resolution to questions and change requests that arise regarding data content, completeness and reporting.
12. CONTRACTOR(S) shall receive amended standards with advance notice and make any changes or corrections to any systems, processes, or data transmission formats as needed to comply with data quality standards. CONTRACTOR(S) shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.
13. In the event the State finds the CONTRACTOR(S) to be out-of-compliance with program standards, timeline submissions, performance standards, or the terms and/or conditions of this CONTRACT, the State shall issue a written notice of deficiency. The State will require a corrective action plan (CAP) and/or specify the manner and timeframe in which the deficiency is to be cured. If the CONTRACTOR(S) fails to cure the deficiency as ordered, the State shall have the right to exercise administrative sanction options, in addition to any other rights and remedies that may be available to the State.
14. CONTRACTOR(S), in response to this RFP, shall demonstrate experience and expertise with all data submissions in scope of this RFP. Evaluation will be conducted on the following criteria:
15. The adequacy of the respondent’s process to ensure accurate, timely, and complete data and reporting submissions.
16. Demonstrated knowledge of the combination of key fields needed to identify services.
17. Adequacy of procedures for quality control, coding consistency, consistency across data sources.
18. Completeness of flowchart describing data submission.
19. Adequacy of mechanisms for tracking, trending, monitoring data submissions, and revisions.
20. Ability to implement timely corrective actions.
21. Adequacy of tools and methodologies used to determine compliance.

### Reports and Audits

1. General Reporting Procedures: The CONTRACTOR(S) shall comply with all the reporting requirements established by the State and listed in the KanCare Reporting System. The CONTRACTOR(S) shall be informed by the State of any report additions or changes to existing reports when these additions or changes are made. The State may modify reports, specifications, templates or timetables as necessary during the CONTRACT. CONTRACTOR(S)’ changes to the format must be approved by the State prior to implementation and must not disrupt the continuity or comparability of the date reported. Specific reporting requirements are identified in this CONTRACT and in Attachment H to this RFP, which incorporates the Kansas Reporting Grid as the summary of periodic reporting requirements and is subject to change over time. The CONTRACTOR(S) must maintain a health information system that collects, analyzes, integrates, and reports data. The CONTRACTOR(S) shall create reports using the formats, including electronic formats, instructions, and timetables as specified by the State, at no cost to the State. All reports must be accurate and auditable. Report output must be clear and easily understandable to the end user. The CONTRACTOR(S) shall, upon request of the State, generate any additional data or reports at no additional cost to the State, within a time period prescribed by the State.
2. The CONTRACTOR(S) must take the following steps to ensure that data received from Participating Providers is accurate and complete: Verify the accuracy and timeliness of reported data; screen the data for completeness, logic and consistency; and collect utilization data in standardized formats as requested by the State. As part of its QAPI program, the CONTRACTOR(S) shall review all reports submitted to the State to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward. The CONTRACTOR(S) shall transmit and receive all transactions and code sets in the appropriate standard formats as specified under HIPAA. The CONTRACTOR(S) shall submit all reports electronically and in a manner and format prescribed by the State. The CONTRACTOR(S)’ failure to submit the reports as specified may result in the assessment of liquidated damages as described in Attachment G. Standards applied for determining adequacy of required reports are as follows:
3. Timeliness: Reports or other required data shall be received on or before scheduled due dates.
4. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or State defined standards.
5. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.
6. Fees: CONTRACTOR(S) is prohibited from charging additional fees for any report requested by the State.
7. Reporting Requirements: The CONTRACTOR(S) shall provide reports to the State in the frequency specified by the State, following the format(s) developed by the State in collaboration with the CONTRACTOR(S), and approved by the State. Initial reporting formats must be developed and approved prior to the implementation of the program covered by this CONTRACT, must meet all CONTRACT and legal reporting requirements, and must include uniform and standardized elements so that the information reported is comparable across all CONTRACTOR(S)/Subcontractors. Ongoing and additional reporting issues and formats are subject to development and revision as necessary across the time span of this CONTRACT, and each such report must be consistent with the criteria described above and presented to/approved by the State prior to use. The CONTRACTOR(S) agrees to furnish information, as required, from its records to the State and the State’s authorized agents and to provide an assessment of identified deficiencies and CONTRACTOR(S)’ proposed CAP which the State will use to correct any identified deficiencies, including but not limited to the following:
8. Additional/Ad-hoc Reports: Upon request by the State, the CONTRACTOR(S) shall prepare and submit other operational data reports, including Behavioral Health and LTSS reports. Such requests will be limited to situation in which the desired data is considered essential and cannot be obtained through existing CONTRACTOR(S) reports. Whenever possible, the CONTRACTOR(S) will be provided with sixty (60) days’ notice and the opportunity to discuss and comment on the proposed requirements before work is begun. However, the State reserves the right to give thirty (30) days’ notice in circumstances where time is of the essence.
9. Ad Hoc Reports: The CONTRACTOR(S) will provide ad hoc reports for LTSS and Behavioral Health data to KDHE-DHCF within reasonable time frames of request.
10. CAP: The State may require corrective action in the event that any report, filing, examination, audit, survey, inspection, or investigation should indicate that a CONTRACTOR(S), or any Subcontractor is not in substantial compliance with any material provision of this CONTRACT, or in the event that the State receives a substantiated Grievance or Appeal regarding the standard of care rendered by the CONTRACTOR(S) or any Subcontractor. The State may also require the modification of any policies or procedures of a CONTRACTOR(S) relating to the fulfillment of its obligations pursuant to this CONTRACT. Should the State desire to take any such corrective action it must issue a written deficiency notice and require a CAP to be filed by the CONTRACTOR(S) within fifteen (15) calendar days following the date of the notice. A CAP shall delineate the time and manner in which each deficiency is to be corrected. The plan shall be subject to approval by the State, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan. The State may extend or reduce the time allowed for corrective action depending upon the nature of the deficiency.
11. General Audit Procedures: The CONTRACTOR(S), the CONTRACTOR(S)’ parent company, and all Subcontractors that are affiliated and not affiliated with CONTRACTOR(S) will provide the results of an annual audit performed by an Independent Certified Public Accountant and to authorize the CONTRACTOR(S) to share this information with the State. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report.
12. Throughout the duration of the CONTRACT, and for a period of ten (10) years after termination of the CONTRACT or from the date of completion of the audit, in accordance with 42 CFR § 438.3(h), the CONTRACTOR(S) and any Subcontractors shall provide duly authorized representatives of the State or Federal government, access to all records and material, including financial records, relating to the CONTRACTOR(S)’ provision of and reimbursement for activities contemplated under the CONTRACT. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the CONTRACT.
13. Allow duly authorized agents or representatives of the State and Federal government, during normal business hours, access to the CONTRACTOR(S)’ premises or the CONTRACTOR(S)’ Subcontractor’s premises to inspect, audit, monitor or otherwise evaluate the performance of the CONTRACTOR(S)’ or Subcontractor’s contractual activities and shall forthwith produce all records requested as part of such review or audit.
14. In the event right of access is requested under this section, the CONTRACTOR(S) or Subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort. In practice, the State notifies any entity audited well before the actual audit occurs. A pre-entrance conference is scheduled to inform the CONTRACTOR(S) about the process. Audits are generally scheduled at a mutually agreed upon time. However, there may be unusual circumstances which require that the State perform an audit with minimal notice. These circumstances would include alleged failure to comply with the CONTRACT. If the CONTRACTOR(S) complies with the CONTRACT, the timing of any audit is unlikely to be a problem.
15. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of CONTRACTOR(S)’ or Subcontractor’s activities. The CONTRACTOR(S) shall be given ten (10) business days, or an amount of time agreed upon by the State and the CONTRACTOR(S), to respond to any findings of an audit before the State shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.
16. Identification of Patients for Purposes of Making Disproportionate Share Hospital (DSH) Payments: The CONTRACTOR(S) shall provide to the State information necessary to determine the hospital services provided under the CONTRACT (and the identity of hospitals providing such services) for purposes of calculating Disproportionate Share Payments.
17. Record keeping requirements: CONTRACTOR(S) must retain, at a minimum, all data, information, and documentation specified in 42 CFR § 438.3(u) and as directed by the State for a minimum of ten (10) years.

### Imposition of Sanctions

1. Imposition of Sanctions: The State shall issue a written notice to the CONTRACTOR(S) indicating the violation(s) and advising the CONTRACTOR(S) that failure to cure the violation(s) within a defined time period to the satisfaction of the State, may lead to the imposition of any sanction or combination of sanctions provided by the terms of this CONTRACT, or otherwise provided by State or Federal law, including but not limited to the following:
2. Suspension of further Enrollment for a Defined Time Period: When the State determines the CONTRACTOR(S) is out of compliance with the CONTRACT, the State may suspend the CONTRACTOR(S)’ right to new enrollment under this CONTRACT. The suspension will take effect if the non-compliance remains uncorrected at the end of the notice period. The State may suspend enrollment sooner than the time period specified in this paragraph if the State finds that Members’ health or welfare is jeopardized. The suspension period may be for any length of time specified by the State, or may be indefinite. The suspension period may extend to the expiration of this CONTRACT.
3. Suspension of capitation payments.
4. Suspension or recoupment of the Capitation Payment paid for any month for any Member who was denied the full extent of Covered Services meeting the standards set by this CONTRACT, or who received or is receiving substandard services.
5. Intermediate sanctions for non-compliance as specified in 42 CFR § Part 438, subpart L.
6. Liquidated damages.
7. Termination of this CONTRACT.
8. All reports must be stratified as directed by the State.

### High Level Scope of Work of KMMS

#### KMMS Background

The State of Kansas, Department of Health and Environment, Division of Health Care Finance has contracted with DXC technology to develop and implement a (MMIS based on Medicaid Information Technology Architecture (MITA) 3.0 standards. KDHE is preparing for the increasing number of healthcare reform initiatives taking place over the next few years.

The MCOs will not only be a user of the MMIS, but also have contractual obligations to assist Providers with training and addressing Provider inquiries at their helpdesks. Therefore, MCO staff will be involved in the planning and in supporting the implementation aspects of the KMMS system in order to better support and coordinate subtasks of the KMMS project plan. MCOs are responsible for projects such as interfacing their systems to the MMIS using the framework and protocols depicted in figure-1 below and fulfilling their contractual obligations with Medicaid Providers.

**Objectives of the Kansas Modular Medicaid System**

The following are KDHE’s goals for the modular MMIS:

1. Meet the Kansas Medicaid Information Technology Architecture (MITA) 3.0 objectives using the existing Kansas Service-Oriented Architecture (SOA) as shown in figure-1 below.
2. Meet CMS’ Seven Conditions and Standards (7C&S) and promote the use of industry standards for information exchange and interoperability, providing a seamless business services environment for KDHE users.
3. Provide information management tools to assist KDHE in effectively managing the State Medicaid program, business processes, and provide a system designed to accommodate the information needs and business methods of today and tomorrow.
4. Implement eight module components to modernize or replace the existing MMIS that has been in operation since year 2002. A Module is functional grouping of capabilities that will be implemented, tested, and certified as a single group of system functionality.
5. Support monitoring the performance of KanCare MCOs.
6. Implement a system that can handle clinical data, encounter and claim processing, and multiple payment methodologies.

#### KMMS Architecture

##### KMMS Framework

The State and DXC are implementing an MMIS framework that utilizes the Oracle®[[1]](#footnote-1) Service Bus (a component of the Oracle SOA Suite) for the SOA platform, Business Rules Engine (BRE), and Oracle Identity Management (OIM) for security roles in alignment with the CMS MITA Leverage Condition. Figure 1, below, represents the proposed KMMS framework and a portion of the State framework. This diagram provides a conceptual view of the functional areas of shared services desired by the State.

All external partners to KMMS like MCOs will be required to use the shared services using the Enterprise Service Bus (ESB). The CMS leverage requirement is a key driver for the State requiring the Contractor(s) to use the Oracle ESB.

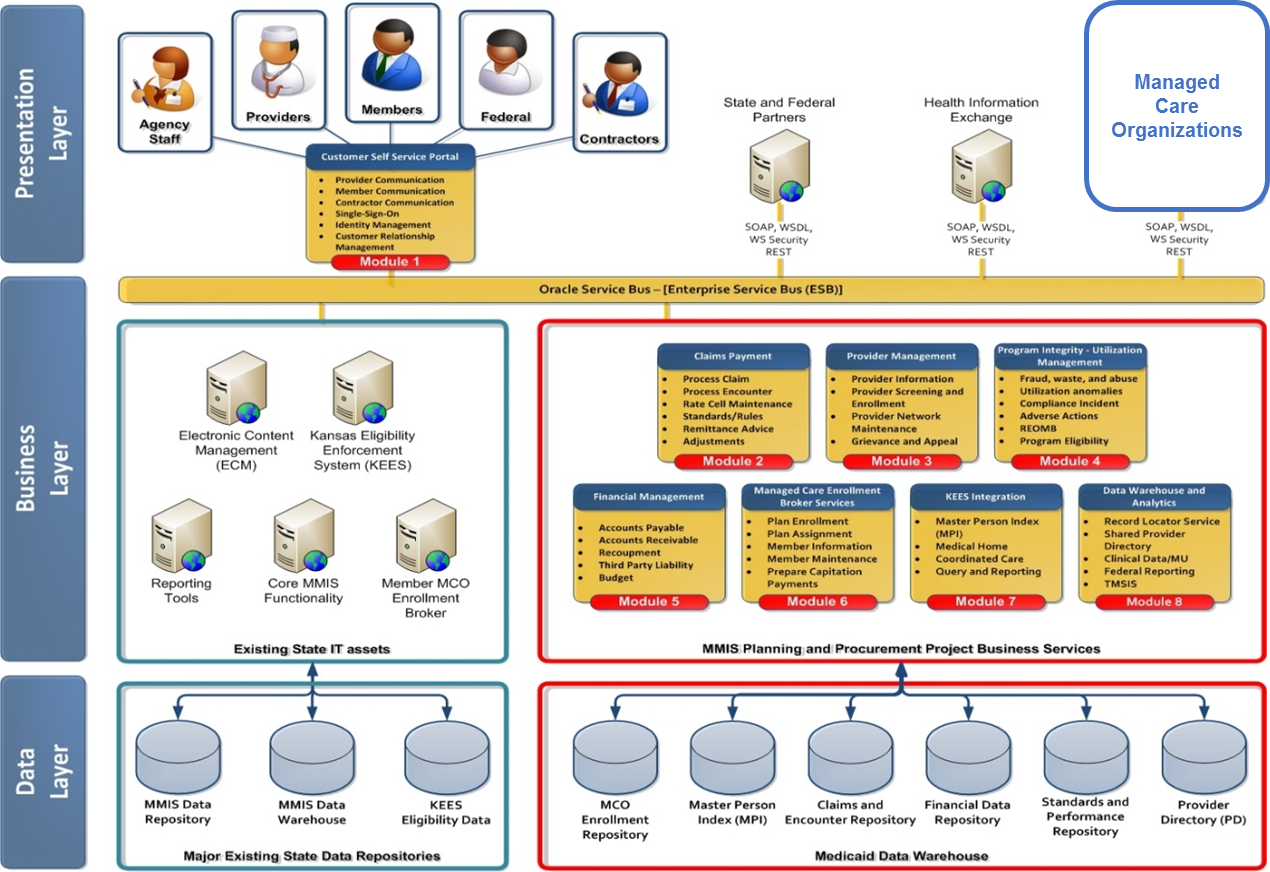


Figure 1, above, illustrates the State’s Oracle framework and KMMS framework for a modernized MMIS. Development of a modernized, modular MMIS will include the following major categories of shared services:

1. Module 1: Customer Self Service Portal (CSSP)
2. Module 2: Claims Payment/Encounter Processing
3. Module 3: Provider Management
4. Module 4: Program Integrity/Utilization Management
5. Module 5: Financial Management
6. Module 6: Managed Care Enrollment Broker Services
7. Module 7: Kansas Eligibility and Enforcement System (KEES) Integration
8. Module 8: Data Warehouse and Analytics (DWA)

The KMMS framework ensures compliance with the CMS Seven Conditions and Standards (7C&S):

1. The Modularity Standard, which requires a modular, flexible approach to systems development.
2. The MITA condition requires states to align to, and increasingly advance in their MITA maturity for business, architecture, and information (data) architectures.
3. The Industry Standards Condition ensures that states align with and incorporate current industry standards.
4. The Leverage Condition that promotes solution sharing, leveraging, and the reuse of Medicaid technologies and systems within and among states.
5. The Business Results Condition which supports the accurate, timely processing and adjudication of the ever expanding definition of claims (includes claims of eligibility), and effective communication with Providers, clients, MCOs, and the at large public.
6. The Reporting Condition that requires the states to generate and analyze transaction data, reports, and performance metrics.
7. The Interoperability Condition that requires a seamless coordination and integration with:
8. Exchange data services solutions, such as a Health Insurance (or benefit) Exchange (HIX) (regardless of whether the service is run by a state or the federal government), that promotes interoperability for increased health outcomes
9. Managed Care Organizations
10. Other State agencies and programs
11. Local organizations and community providers
12. National organizations or governing bodies

##### Responsibilities of the MCOs

1. Understand the goal of KME with MITA 3.0 and implementation of KMMS framework as described above.
2. Work with KME and DXC project teams to implement real time web services interface(s) for exchanging data between MCO systems and KMMS using standard-based protocols including but not limited to: Simple Object Access Protocol (SOAP), Representational State Transfer (REST) web services/APIs, Web Services Definition Language (WSDL) messaging, and Web Services (WS-Security).
3. Support KME’s vision to access applications through Single-Sign-on capability.
4. Use of standard EDI HIPAA transaction sets whenever such standards are available instead of using proprietary files for exchanging data.
5. Be aligned with KME’s goal to meet CMS 7C&S (as described above).
6. Coordinate with KME and DXC on KMMS project implementation dates related to interface implementation and testing.
7. Work with KME and DXC to provide test data from MCO systems for non-production environment testing.
8. Participate in complete end-to-end testing of modules wherever data is needed from the MCO systems.
9. Work with KME and DXC to implement any changes that may be required in future versions of MITA.

## Staffing

### CONTRACTOR(S) Staffing Requirements

CONTRACTOR(S) shall have in place the organization, management and administrative systems necessary to fulfill all contractual requirements of this RFP. The CONTRACTOR(S) shall demonstrate to KDHE-DHCF’S satisfaction that it has the necessary dedicated, non-delegable Kansas staffing, by function and qualifications, to fulfill its obligations under this CONTRACT.

The CONTRACTOR(S) is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties as contained herein, regardless of the level of staffing included in the CONTRACTOR(S)’ proposal. The information provided in this section is not intended to define the overall staffing levels needed to meet CONTRACT requirements. In the event that the CONTRACTOR(S) does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, KDHE-DHCF may impose liquidated damages (see Attachment G). Following is a list of items to be addressed in this section of the proposal:

1. Staffing Plan: The CONTRACTOR(S) shall describe its staffing plan for the managed care CONTRACT. The proposal shall outline how the staffing plan will achieve consistent, dependable service regardless of changes that may directly influence work volume as required in Section 5.17.1.B below. The proposal shall also provide a general description of the CONTRACTOR(S) proposed staff with number of years of experience in their fields and number of years of experience in the managed care field and any other requirements as required in Section 5.17.2. In addition CONTRACTOR(S) shall:
2. Report Key Personnel departures to State staff no later than five (5) business days from learning of the intended departure, to the extent possible.
3. Report Key Personnel role changes to the State within five (5) business days of learning of the change, to the extent possible.
4. Notify the State at least thirty (30) calendar days in advance of any plans to change, hire, or re assign designated Key Personnel.
5. Develop a system and training program to ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible.
6. Fill key positions on an interim basis within fifteen (15) calendar days of departure (notifying the State of the interim person and a summary of his/her qualifications), and on a permanent basis within ninety (90) calendar days of departure, unless a different timeframe is approved by the State. The replacement must be a qualified individual approved by the State.
7. Identify a minimum staffing level defined over time and maintain that defined minimum staffing level at all times during designated business hours.
8. Each proposal must describe the CONTRACTOR(S)’ back-up personnel plan, including a discussion of the staffing contingency plan for:
9. The process for replacement of personnel in the event of the loss of Key Personnel or other personnel before or after signing a CONTRACT.
10. Allocation of additional resources to this CONTRACT in the event of inability to meet a performance standard.
11. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.
12. The timeframes necessary for obtaining replacements.
13. Method of bringing replacements or additions up-to-date regarding this CONTRACT.

### CONTRACTOR(S) Key Personnel

This section identifies designated Key Personnel and certain other staff where specific requirements for the position shall be met by the CONTRACTOR(S). Individuals filling Senior Executive, Officer and Director level designated Key Personnel positions must be approved by the State. As part of its response to this proposal the CONTRACTOR(S) shall identify and request any exceptions to the Key Personnel positions listed below. Such exception requests shall clearly identify the reason for the exception and the value the change results in to Kansas and the population served under the KanCare program. The CONTRACTOR(S) shall describe how it will meet the first year requirements of the Individuals with Disabilities Hiring Plan goal of 5%.

1. The minimum Key Personnel positions are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.
2. All Key Personnel are to be exclusively dedicated to the KanCare CONTRACT and physically based in Kansas and must have Kansas licensure as appropriate, unless otherwise specified below.
3. Key Personnel include:
4. A full-time Senior Executive / project director exclusively dedicated to the KanCare program who has clear authority over the general administration and day-to-day business activities of this Agreement.
5. A full-time Senior Executive finance officer exclusively dedicated to the KanCare program responsible for accounting and finance operations, including all audit activities.
6. A full-time Compliance Officer exclusively dedicated to the KanCare program, responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the CONTRACT. The Compliance Officer shall report directly to the CEO and the Board of Directors.
7. A full-time Medical Director or CMO exclusively dedicated to the KanCare program who is board certified and a licensed physician in the State of Kansas. The CMO shall be responsible for all clinical activities, including but not limited to the proper provision of Covered Services to Members; UM activities, developing clinical practice standards and clinical policies and procedures. The CMO shall act as a champion supporting continuous quality improvement efforts to improve the care and services delivered to all populations covered under the KanCare CONTRACT and shall work directly with all other Medical Officers and Department and Business unit leads to promote excellence in care and service delivery.
8. A full-time LTSS Clinical Officer/Medical Director (LTSS CO/MD) who is board certified in Geriatrics or a Gerontological Nurse Practitioner, licensed in the State of Kansas, who is exclusively dedicated to the KanCare CONTRACT and who has at least five (5) years of experience in directing health care services for FE or individuals of any age with physical, intellectual and/or developmental disabilities. The LTSS CO/MD shall oversee and be responsible for all primary and physical and Behavioral Health services provided to individuals receiving LTSS, and to comparable populations enrolled in KanCare, and all clinical activities pertaining to the operation of LTSS programs and services, including Preventive Care and the management and coordination of Chronic Conditions and physical health needs, and the integration and coordination of primary and other physical health services for Members receiving LTSS. The LTSS CO/MD shall also be responsible for working with the CMO, Behavioral Health CMO (BH-CMO), Pharmacy Director and the Behavior Supports Director to ensure the integration of physical and Behavioral Health services and supports and LTSS, as applicable, for individuals in each of these populations and to oversee the CONTRACTOR(S)’ quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.
9. A full-time LTSS Director/Manager dedicated to the KanCare LTSS initiatives including care coordination efforts, housing, employment, transportation and community integration activities required for a high performing LTSS system. This position will work closely with the Medical Officers, Quality Director and other clinical partners to provide direction to improve coordination and implement community-based and institutional initiatives, e.g., programs designed to address transitions from long-term institutional settings or Social Determinants of Health and Independence.
10. A full-time Behavioral Health Medical Officer/Medical Director (BH-CMO) who is a board certified psychiatrist and addictionologist (or State approved addictions experience), exclusively dedicated to the KanCare CONTRACT and is a licensed physician in the State of Kansas and who has at least five (5) years combined experience in mental health and SUD services. This person shall oversee and be responsible for all Behavioral Health activities, including oversight of coordination activities with KDADS and shall work closely with the Behavioral Health Supports Director and other Medical Officers to ensure the delivery of holistic and integrated person-centered care. KDADS must review and approve staffing of this position in advance of an offer being extended.
11. A full-time Behavior Health Supports Director exclusively dedicated to the KanCare program and the populations served in LTSS and Behavioral Health and who is a Kansas licensed psychologist or board certified Psychiatric Mental Health Nurse Practitioner or Clinical Nurse Specialist with an Advanced Practice Nursing (APN) degree and experience with Applied Behavior Analysis and directing behavior support services. The Behavior Supports Director shall oversee and be responsible for behavior support services provided to individuals receiving LTSS, and comparable populations. The Behavior Supports Director shall be responsible for working with the BH-CMO to oversee the ongoing management of Behavior Crisis Prevention, Intervention and Stabilization Services and shall be responsible for working with the other Medical Officers and the Pharmacy Director to ensure the integration of physical and Behavioral Health services and supports and LTSS, as applicable, for individuals in each of these populations, and to oversee the CONTRACTOR(S)’ quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.
12. A full-time Pharmacy Director exclusively dedicated to the KanCare program who is a licensed Pharmacist in the State of Kansas to oversee and be responsible for all clinical and administrative Pharmacy activities, including but not limited to: proper provision of pharmaceutical services to Members and developing and maintaining Pharmacy practice standards and Pharmacy policies and procedures. This position shall interface with the Medical Officers, the Behavioral Health Supports Director and other CONTRACTOR(S) staff to ensure integration of Pharmacy data into the integration, management and quality improvement efforts of the CONTRACTOR(S).
13. A full-time QM Director exclusively dedicated to the KanCare program with at least five (5) years of experience performing HEDIS data collection, integrating rapid-cycle process improvement principles in an organization and utilizing study design and evaluation approaches to improve quality of care and service delivery. This position is responsible for executing the QAPI requirements found in Section 5.9 in accordance with the State’s Quality Management Strategy and for infusing continuous quality improvement approaches throughout the organization.
14. A full-time Chief Data Analytics Coordinator exclusively dedicated to the KanCare CONTRACT with a minimum of three (3) years of experience aggregating disparate data sets and analyzing data with the intent of identifying trends and opportunities for improvement. In addition to reviewing data across populations and programs, including data from vendors such as Behavioral Health, Pharmacy, transportation etc., this position is responsible for facilitating and responding to ad-hoc data requests from the State and internal business units, coordinating, reviewing and validating all data and reports sent to the State, and acts as a resource to ensure appropriate data and data analytic support and services are available to support rapid-cycle process improvement efforts across the CONTRACTOR(S)’ enterprise and to meet all reporting and quality improvement efforts under this CONTRACT. This position shall work closely with the QM Director and the Information Systems Director/Manager.
15. A full-time Member Services Director/Manager who is exclusively dedicated to the KanCare CONTRACT and who shall be responsible for Member services, including, among others, the Member services Call Center, and the CONTRACTOR(S)’ health literacy, health education and cultural competency efforts. This individual shall oversee the Member Advocates and work closely with other business units to ensure member-centric service delivery.
16. A full-time Health Services Director/Manager who is exclusively dedicated to the KanCare CONTRACT and responsible for all UM activities, including but not limited to overseeing PAs. This person shall be under the direct supervision of the CMO and shall ensure that UM staff have appropriate clinical licensure and experience in order to make UM decisions. This person will also be responsible for coordinating with the Behavioral Health and LTSS Medical Officers, Pharmacy Director and Behavioral Health Supports Director and other network staff to ensure delivery of holistic, integrated and person-centered care.
17. A full-time Service Coordination Director/Manager responsible for all Service Coordination activities, within the Service Coordination Program for all KanCare Members. The Service Coordination Director shall be a Kansas licensed clinician with at least five (5) years case and Care Management experience and who is knowledgeable about all KanCare Waiver programs and who will provide oversight for the CONTRACTOR(S)’ quality improvement initiatives regarding care coordination, Social Determinants of Health and Independence, and health Outcomes. This position will work closely with the Behavioral Health Supports Director and the Health Services Director to provide integrated, holistic care for all KanCare populations covered under the KanCare CONTRACT.
18. A full-time Provider Relations Director/Manager who is exclusively dedicated to the KanCare CONTRACT and responsible for Provider services and Provider relations, Provider payment issues, Provider education, development and execution of Provider training as described in Section 5.6 and who shall act as the single point of contact to the State to address escalated Provider issues.
19. The CONTRACTOR(S) shall identify one or more dedicated LTSS and Behavioral Health Provider representatives for LTSS and Behavioral Health Providers. LTSS and Behavioral Health Provider representative(s) shall be responsible for internal representation of Providers’ interests including, but not limited to, contracting, service authorizations, claims processing and other LTSS and Behavioral Health Provider needs.
20. The LTSS and Behavioral Health Provider representatives shall conduct ongoing communications with LTSS and Behavioral Health Providers through Provider forums, webinars, dedicated toll-free LTSS Provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes.
21. A full-time Network Management and Contracting Director/Manager who is exclusively dedicated to the KanCare CONTRACT and responsible for all network development staff, developing and implementing the Network Development Plan described in Section 5.5.2 and assessing network adequacy and availability including expanding use of tele-medicine and other innovative strategies to improve network access and availability.
22. The CONTRACTOR(S) shall identify at least one staff member exclusively dedicated to the KanCare CONTRACT to be responsible for oversight and coordination of all Subcontractors and delegated entities. This person shall be responsible for coordinating the Delegation Oversight (sub)-Committee, coordinating annual audits, facilitating joint operational meetings between the CONTRACTOR(S) and its Subcontractor(s) and interfacing with other internal business units impacted by the Subcontractor(s).
23. A full-time Transition of Care coordinator exclusively dedicated to the KanCare CONTRACT with demonstrated expertise in facilitating and coordinating care transitions across the continuum of care settings and throughout the Member’s life-span. This position should report to the Care Coordination Director/Manager and is responsible for working across internal business units and directly coordinating with care coordination staff, external community entities and Participating Providers to provide advice and support for complex transition of care cases.
24. A full-time staff person exclusively dedicated to overseeing Housing Services and Supports for LTSS and Behavioral Health programs and services. This person shall have at least three (3) years’ experience in assisting the elderly and persons with disabilities to secure accessible, affordable housing through Federal (such as HUD, Shelter Plus Care, SAMHSA, and USDA), as well as, local programs. The Housing Specialist shall work under the Housing First Model, honoring Member choice. The Housing Specialist shall be responsible for working with the aforementioned housing agencies and other Housing programs to help develop and access affordable housing services for Members receiving LTSS, educating and assisting Care/Support Coordinators regarding affordable housing services for KanCare Members, and liaison with KDADS housing coordinators and housing specialists within each Community Mental Health Center on Kansas’ broader housing strategy and initiatives. The housing specialist will work with KDADS to ensure that Community Providers are trained and achieving fidelity in evidence-based practices (i.e. Housing First Model).
25. A full-time Employment Services and Supports Coordinator exclusively dedicated to the KanCare CONTRACT and responsible for overseeing Employment Services and Supports for LTSS programs and services. This person shall have at least three (3) years’ experience in developing employment services and supports for persons with disabilities in integrated settings, which shall include at least one (1) year experience directing such programs and services; or other significant and relevant employment services expertise as approved by KDADS in writing. The Employment Services and Supports Coordinator shall be responsible for coordination with the Working Healthy/WORK program, the Kansas Workforce Centers, Kansas Rehabilitation Services, and the Kansas Departments of Education, to assist the State in increasing competitive integrated employment of youth and adults with disabilities. The CONTRACTOR(S) shall also assist the State with any new employment initiatives the State may implement, and provide ongoing leadership of employment services and supports for the CONTRACTOR(S)’ staff and Participating Providers. A staff person in this position must successfully complete Association of Community Rehabilitation Educators (ACRE) Professional Level Employment Training, as well as, be a SOAR certified specialist with KDADS and the Social Security Administration either prior to or during the first year of employment. A staff person in this position must be familiar with the Individual Placements and Supports (IPS) supported employment model, and any other evidence-based employment models used by the Community Mental Health Centers.
26. A full-time EPSDT Coordinator exclusively dedicated to the KanCare CONTRACT responsible for all KAN Be Healthy services and related issues, including but not limited to, all KAN Be Healthy Kids activities and EPSDT screening events. This position shall inter-face and coordinate with the Foster-Care Coordinator, Director of Care Coordination, the Member Advocate and other internal staff to ensure the delivery of all preventive screenings and to ensure delivery of appropriate treatment and follow up based on identified diagnoses.
27. A full-time Foster Care Coordinator responsible for working with the DCF and the KDADS who has demonstrated experience working in the Foster Care system to help CONTRACTOR(S) staff, Members and families navigate through and coordinate with various programs and systems of care.
28. A full-time Grievance and Appeal Director/Manager exclusively dedicated to the KanCare CONTRACT responsible for managing Member Grievances, Reconsiderations and Appeals including requests for State Fair Hearings.
29. A full-time Provider Appeals Director/Manager responsible for managing Provider appeals.
30. At least two full-time Member Advocates (one for LTSS and one for Behavioral Health), exclusively dedicated to the KanCare CONTRACT who shall have at least two (2) years of experience in a health care related field with requisite experience working with either LTSS or Behavioral Health populations, preferably working with low-income populations, and have demonstrated expertise in topics related to LTSS, resiliency and recovery and Cultural Competency. The Member Advocates shall be responsible for the following activities:

Act as the single point of contact between the State and the CONTRACTOR(S) for escalated Member concerns and questions.

Investigate and resolve access and cultural sensitivity issues identified by CONTRACTOR(S) staff, State staff, Providers, advocate organizations or Members.

Monitor Grievances with Grievance personnel to look at trends or major areas of concern.

Work with care coordinators to help link Members to necessary services and supports.

Coordinate with the schools, community agencies and State agencies, with special emphasis on foster children and providing services to Members.

Recommend policy procedural changes to CONTRACTOR(S)’ management including those needed to ensure/improve Member access to care and quality of care (changes can be recommended for both internal administrative policies and Provider requirements).

Identify a staff person to function as a primary contact for Member advocacy groups and work with these groups to identify and correct Member access barriers.

Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of Members.

Analyze systems functions through meetings with staff.

Organize and provide training and educational materials for CONTRACTOR(S)’ staff and Providers to enhance their understanding of the values and practices of all cultures with which the CONTRACTOR(S) interact.

Provide input to CONTRACTOR(S)’ management on how Provider changes will affect Member access and quality/continuity of care and develop/coordinate plans to minimize any potential problems.

Review all informational material to be distributed to Members.

Assist Members and Member representatives in obtaining medical records.

1. A full-time staff Information Systems Director/Manager exclusively dedicated to the KanCare CONTRACT responsible for all CONTRACTOR(S) information systems supporting this CONTRACT who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this CONTRACT including, but not limited to, establishing and maintaining connectivity with KanCare information systems and providing necessary and timely reports to KanCare.
2. A full-time Claims/Operations Manager exclusively dedicated to the KanCare program who is qualified by training and experience to oversee claims and Encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness and completeness of processing payment and reporting.
3. All Key Personnel shall be employed by, or committed to join, the CONTRACTOR(S)’ organization by the beginning of the pertinent CONTRACT phase or task.
4. Other Personnel - The proposal shall also include a description of the numbers, types and functions or position descriptions of other staff. The description should address changes in membership and should be updated as program changes affect staffing.
5. In keeping with Kansas values of a strong work ethic and the understanding that work builds self-esteem and provides financial security and that people with disabilities who are ready, willing and able to work are healthier when they do, it is vitally important that people with disabilities are employed in integrated settings in the work place. Therefore, the CONTRACTOR(S) shall hire people with disabilities and shall be able to demonstrate what percentage of their workforce helps them to meet this requirement. The CONTRACTOR(S) shall adopt hiring practices which establish a preference for considering employment opportunities for individuals with disabilities. The plan for hiring practices must be approved by the State.
6. Each CONTRACTOR(S) shall develop Individuals with Disabilities Hiring Plan and adopt practices to ensure at least 5% of its Kansas based staff are comprised of individuals with disabilities by the end of the first year of operation.
7. Each subsequent CONTRACT year the CONTRACTOR(S) shall increase its hiring of individuals with disabilities by a minimum of 1% or until it has reached 10% of its total Kansas-based staff.
8. In accordance with K.S.A. 75-3317 through 75-3322, “The Kansas Use Law,” CONTRACTOR(S) are encouraged to purchase goods and services from Kansas Use Law vendors, and doing so shall contribute to the CONTRACTOR(S) hiring of appropriate percentages of disabled staff, as required in Section 5.17.2. G.1.and 5.17.2.G.2. (e.g., CONTRACTOR(S) are encouraged to utilize mail room service by a qualified Use Law vendor).
9. Within sixty (60)-calendar days of CONTRACT award the CONTRACTOR(S) shall develop an Individuals with Disabilities Hiring Plan that outlines the CONTRACTOR(S)’ activities to meet the State established goal and how it will ensure the expansion of employment opportunities for individuals with disabilities.
10. The Individuals with Disabilities Hiring Plan shall be evaluated on an annual basis and made available to the State and stakeholders upon request, and shall address barriers to attaining specific goals as well as interventions to be placed to meet the required goals.
11. The CONTRACTOR(S) shall use the conditions contained in The ADA of 1990 as the guideline for development of its Disability Hiring Plan.
12. Failure to meet the Individuals with Disabilities Hiring Plan goals may result in penalties as outlined in Attachment G.
13. Community Partnership: The proposal shall also include information on how the CONTRACTOR(S) will build partnerships with Community Based Organizations, trade associations, faith based organizations and other community entities to provide guidance, direction and support to the CONTRACTOR(S) and the CONTRACTOR(S)’ staff in the form of technical assistance, training and education to support the delivery of person-centered, culturally competent and integrated care to all populations.

### Staff, Training, and Education

As part of the response the CONTRACTOR(S) must submit its staff training and education plan that, at a minimum, incorporates the following requirements and identifies which staff will receive which training:

1. CONTRACTOR(S) shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure that all staff and the staff of its Subcontractors and delegates can fulfill the requirements of the positions they hold and to ensure competency in and compliance with this CONTRACT. The CONTRACTOR(S) shall use the most appropriate training methods, which may include instructor-led and web-based trainings.
2. The CONTRACTOR(S) shall submit an annual staff training and education plan for KDHE-DHCF approval that details the CONTRACTOR(S)’ staff training and education activities, including the frequency of training, training topics and targeted staff audience. In addition, the CONTRACTOR(S) shall report on the status of the staff training and education plan activities on a quarterly basis.
3. The staff training and education plan must include a specific training and education plan for the CONTRACTOR(S)’ and those of any delegates, Service Coordination staff found in Section 5.4.10.
4. The CONTRACTOR(S) shall have a Staff Training Coordinator who is responsible for developing, overseeing and evaluating the CONTRACTOR(S)’ staff training and education plan.
5. Staff training may include any topic that the CONTRACTOR(S) deems relevant, but shall include the following minimum requirements:
6. Continuous quality improvement principles and the rapid-cycle process improvement approach.
7. Advance Directives.
8. Member Rights.
9. Cultural Competency.
10. Concepts in Community integration and independent living, including:

Functional limitations and/or chronic illnesses that impact on individuals living or working in the community.

Social Determinants of Health and Independence.

1. Early identification of LTSS Members who may be candidates for NF diversion.
2. Compliance with HIPAA and other State and Federal rules and regulations.
3. Topics related to the Pharmacy benefit.
4. The identification and reporting of Adverse Incidents and Member Grievances.
5. Behavioral Health topics, including co-occurring disorders.
6. The WORK program and Other Employment Programs and how to assist all Members with connecting to employment and volunteer opportunities.
7. Transition of care processes for Members as they move throughout the continuum of care settings.
8. The role of the Member Advocates and how to make referrals for assistance.
9. The identification and reporting of Fraud, Waste and Abuse.
10. Any additional training topics as determined by the State.
11. CONTRACTOR(S) shall verify and document that it has met the training requirements in this section of the CONTRACT. The CONTRACTOR(S) must make this documentation available for the State’s review upon request.
12. CONTRACTOR(S) shall develop and implement a process to evaluate the effectiveness and Outcomes of the training provided and document that it has met this requirement.
13. In the event the CONTRACTOR(S) does not maintain a sufficient level of staff training to competently perform the functions, requirements, roles, and duties involved in State Fair Hearing support, KDHE-DHCF may impose liquidated damages.

### Facilities and Equipment

1. The CONTRACTOR(S) shall maintain a Kansas facility within a two (2)-hour drive of the city limits of Topeka, Kansas. This facility shall meet the requirements of the ADA and appropriate fire code. The CONTRACTOR(S) shall limit access to its facilities to appropriate and authorized personnel only, and provide the State with a copy of its security plan. Security from threats and hazards must meet security guidelines specified in 45 CFR § 95.621(f).
2. The facility will serve as the base location for the Member Advocates, Provider Relations, Network Management, Care Coordination and QM functions and staff working in these areas shall be located at this facility, unless the position is considered a field-based staff position. In addition, the Account Director and full-time designated Key Staff must be based at this facility. The CONTRACTOR(S) may perform some development functions outside of Kansas but within the continental United States, and Kansas health data must never leave the continental United States. The CONTRACTOR(S)’ team is generally expected to perform 100% of its work on-site in Topeka except as otherwise proposed, agreed to, and approved by the State. The proposal must clearly explain which positions and functions will be located in the Kansas facility and which are located outside the Kansas facility. If out-of-state (away from Kansas) services are proposed, then the proposed approach shall include appropriate coordination activities necessary to manage and coordinate all out-of-state activity. The State does not expect to manage CONTRACTOR(S)’ personnel, whether located in-state or out-of-state.
3. The CONTRACTOR(S) must limit access to any out-of-state facilities included in the operation, including storage facilities, and must provide the State with a copy of its planned security procedures for all facilities. The State reserves the right to perform physical security checks at the State’s discretion.
4. Generally, the State will NOT provide any facilities or equipment for the CONTRACTOR(S). The State will provide one cubicle for visiting CONTRACTOR(S)’ staff in its downtown Topeka offices.

## WORK Program

1. WORK is the program through which individuals eligible for the Kansas Medicaid Buy-in program, Working Healthy, receive HCBS. Unlike other HCBS programs in Kansas, WORK is not operated under the 1915(c) HCBS Waiver authority. Instead, WORK is authorized under the PPACA as an Alternative Benefit Plan, i.e., it is a Kansas Medicaid State Plan package of services targeting individuals enrolled in Working Healthy who demonstrate a need for such services.
2. WORK includes a needs assessment, personal assistance services, independent living counseling, and assistive services. To receive these services, individuals must first be eligible for Working Healthy, and then demonstrate the same need for services as individuals on the HCBS IDD, PD and TBI Waivers.
3. WORK utilizes a “cash and counseling” model for the provision of personal assistance services. This model goes a step beyond self-direction, allowing Members to manage their funds and purchase personal assistance, providing flexibility in terms of how they purchase their services. Consumers will be given the opportunity to choose how to obtain services in the most cost-effective and innovative manner.
4. Additional information may be found in the Working Healthy Policy Manual located at http://www.kdheks.gov/hcf/workinghealthy/index.htm.
5. WORK Service Coordination Administrative Standards:
6. The CONTRACTOR(S) shall provide Service Coordination services for Members that participate in the WORK program in accordance with the Working Healthy Program Manual and as directed by the State. If the Service Coordination section of the RFP conflicts with the WORK section of the RFP or the Working Healthy Program Manual, the WORK section and the Working Healthy Program Manual shall control.
7. The CONTRACTOR(S) shall maintain written Service Coordination procedures to implement the requirements for WORK Service Coordination.
8. The CONTRACTOR(S) shall designate an individual on the CONTRACTOR(S)’ staff to serve as the State’s primary point of contact for all issues related to the WORK program. The CONTRACTOR(S) shall provide the State with the name and contact information for this individual, who should at a minimum be a supervisor of WORK service coordinators. This individual shall provide timely responses to all State inquiries regarding WORK program participants, coordinating as needed with the CONTRACTOR(S)’ staff, including other WORK service coordinators.
9. WORK Service Coordination Staff Standards
10. The CONTRACTOR(S) shall have an adequate number of qualified and trained service coordinators to serve WORK program participants. The CONTRACTOR(S) shall designate a limited number of service coordinators to serve WORK program participants, as directed by the State.
11. The CONTRACTOR(S) shall ensure that service coordinators serving WORK program participants meet all requirements of the CONTRACTOR(S)’ service coordinators as specified in Section 5.4.8 and the training requirements specified in Section 5.4.10.
12. The CONTRACTOR(S) shall ensure that all newly hired service coordinators serving WORK program participants receive training provided by the State before starting to work with Members. Only service coordinators who receive the proper training may serve WORK participants.
13. The CONTRACTOR(S) must ensure that all service coordinators are provided with regular ongoing training on topics relevant to the Working Healthy/WORK program, including topics identified by the State. Ongoing training shall occur at a minimum annually and to the extent there are changes to the WORK program during the CONTRACT period.
14. Upon monthly notification from the State of all Members eligible for the WORK program, the CONTRACTOR(S) shall assign new Members a service coordinator among the CONTRACTOR(S) designated WORK service coordinators.
15. WORK Service Coordination General Standards
16. The CONTRACTOR(S)’ service coordinators shall provide Service Coordination for Members participating in WORK that facilitates Member understanding and use of WORK program services; accurate assessment of Member service needs; ongoing review, approval and monitoring of Individualized Budgets; and referrals to other resource agencies as needed to address Member needs. See also the Working Healthy Program Manual.
17. In providing Service Coordination to WORK program participants, service coordinators shall actively coordinate with the WORK Program Manager, Working Health Benefits Specialists, and Independent Living Counselors (ILC) to ensure optimum coordination of services.
18. WORK Needs Assessment:
19. The service coordinator must complete a face-to-face WORK needs assessment in the Member’s home within fourteen (14) calendar days of referral for the WORK program from KDHE-DHCF. The needs assessment and any reassessment must occur at the Member’s home.
20. The Member and/or the Member’s representative must be present for the WORK needs assessment.
21. Unless otherwise directed by the State, the CONTRACTOR(S) shall use the WORK Assessment/Allocation Tool provided by the State to conduct the WORK needs assessment.
22. The CONTRACTOR(S)’ service coordinators shall use a person-centered and directed planning process to identify the Member’s needs for WORK program services. To the extent possible, the service coordinator must involve the Member and/or Member representative in needs identification as well as decision making. The assessment shall be developed by the service coordinator with input from the Member/Member’s representative and those individuals the Member chooses to include in the assessment process. See also the Working Healthy Program Manual for additional requirements regarding the WORK needs assessment.
23. After completing the needs assessment, the service coordinator shall send the needs assessment to the ILC so that the ILC can assist the Member in developing an Individualized Budget based on the needs assessment. The Individualized Budget indicates how allocated funds will be used to pay for personal and employment services.
24. The service coordinator shall review the Individualized Budget to ensure it:

Includes all of the required elements.

Meets the needs of the Member.

Reflects the amount, duration and scope of assistance identified during the WORK assessment.

Ensures the emergency backup plan meets all of the criteria specified on the emergency back-up provided by the State.

Confirms there is no conflict of interest contained in the Individualized Budget.

1. The service coordinator shall refer to the Working Healthy Program Manual for descriptions of the amount, duration and scope of services included in the WORK benefit package, including information about limitations.
2. The service coordinator’s supervisor shall review and approve the Individualized Budget.
3. The service coordinator shall review all documentation received from the ILC to ensure that the Member is receiving appropriate services and that the services are being billed correctly.
4. The service coordinator shall provide ongoing management and monitoring of the Member’s monthly allocation and Individualized Budget, including but not limited to: temporary adjustments to the Member’s monthly allocation, monitoring and management of carryover funds, obtaining PA/facilitating the request for approval of assistive services from the CONTRACTOR(S), and requesting a Member’s reassessment (if needed). In performing ongoing management and monitoring functions, the service coordinator shall follow the standards described in the Working Healthy program manual.
5. Annually, the service coordinator shall reassess the Member’s needs for WORK services according to the Working Healthy Program Manual. In addition to the annual reassessment, Members may request a reassessment at any time if the Member experiences a change in their physical condition. All reassessments must occur in the Member’s home.
6. WORK Service Coordination Reporting Requirements
7. The CONTRACTOR(S) shall comply with any reporting requirements the State determines is necessary for the WORK program.
8. Electronic Case Record Standard
9. The CONTRACTOR(S) shall maintain an electronic Case Management system and ensure that a Member’s electronic case record is complete and accurate.
10. The CONTRACTOR(S)’ electronic case record standard must adhere to State and Federal confidentiality, privacy and security standards, including HIPAA.
11. A Member’s electronic case record must include, at a minimum:

Most recent WORK assessment.

Most recent WORK Individualized Budget.

Emergency back-up plan.

Disenrollment from WORK information (if applicable).

Any other requirements included in the Service Coordination Section 5.4.15.

1. WORK Program Disenrollment
2. A Member will be disenrolled from the WORK program based on loss of eligibility for Working Healthy.
3. If the Member has been determined ineligible for WORK, the State will notify the CONTRACTOR(S) and the Member.
4. The service coordinator shall coordinate with the WORK Program Manager to assist Members to return to HCBS Waivers or waiting lists as appropriate.
5. The service coordinator shall update the Member’s electronic case record to reflect service closure activity, including, but not limited to:

Reason for the closure.

Whether the Member will return to an HCBS Waiver or waiting list.

1. WORK Provider Network Requirements:
2. WORK Program Fiscal Management:

The CONTRACTOR(S) shall CONTRACT with a FMS organization to administer the WORK monthly allocations for the CONTRACTOR(S)’ Members who are WORK program participants. The CONTRACTOR(S) shall ensure that the FMS organization for WORK program participants is capable of providing FMS for a cash and counseling program.

The FMS organization contracted to serve WORK program participants can be, but is not required to be, the same fiscal management organization contracted for other programs under the CONTRACT.

The CONTRACTOR(S) shall coordinate with the FMS organization to receive monthly allocation reports at the Member level.

For Members that have been determined ineligible for WORK, the CONTRACTOR(S) shall have a process for coordinating with the FMS organization to receive any portion of the monthly allocation that is unspent within ninety (90) days of WORK services ending.

The CONTRACTOR(S) shall ensure that the FMS organization pays workers’ compensation premiums.

See also the Working Healthy Program Manual for additional requirements for the FMS organization.

1. The CONTRACTOR(S) shall cover the cost of background checks for Personal Assistance Services Providers.
2. The CONTRACTOR(S) shall contract with independent living counselors who meet the requirements/qualifications specified in the Working Healthy Program Manual.
3. Grievances and Appeals
4. Members participating in the WORK program have grievances and appeals rights as described in the Grievances, Reconsiderations and Appeals section and Attachment D.

## MEMBER INDEPENDENCE INITIATIVES

The State may pursue the Member independence initiatives described below during the CONTRACT term. These initiatives are subject to material modifications. The CONTRACTOR(S) shall be required to participate in these initiatives once finalized and approved by CMS.

### KanCare 2.0 Work Requirement Initiative

#### KanCare 2.0 Work Requirement Initiative Description

A. Initiative Description: The State is considering a work requirement for able-bodied adults in KanCare 2.0. This work requirement will be implemented as soon as possible on or after January 1, 2019 and no later than July 1, 2020. All KanCare able-bodied adult members will be subject to the work requirement, with certain exceptions as outlined in the KanCare 2.0 Section 1115 Medicaid Demonstration Waiver Application. KanCare members failing to meet requirements will not be eligible for KanCare coverage.

1. CONTRACTOR(S)’ Responsibilities:
2. The CONTRACTOR(S) shall provide linkage and referral to State of Kansas programs providing employment support services (e.g., Department for Children and Families).
3. Areas of Focus for KanCare 2.0 Work Requirement Initiative
4. Describe any relevant experience the CONTRACTOR(S) have with employment support and workforce development programs in other states.
5. Describe any relevant experience the CONTRACTOR(S) have with providing linkage and referrals to state programs providing employment support services.

### MediKan Employment Opportunity Initiative

#### Medikan Initiative Description

1. MediKan Program: Individuals with disabilities who apply for a disability determination through the Kansas Presumptive Medical Disability process who do not meet the SSA guidelines for a disability determination, or qualify for other State or Federal medical programs, may be eligible to receive a limited state only funded health benefit for a maximum of twelve (12) months under the MediKan program while they continue to pursue an SSA disability determination. Individuals eligible for MediKan tend to have a combination of physical and behavioral conditions that do not meet SSA criteria for a disability, as well as socio-economic issues, that may be a barrier to a stable lifestyle. There were 2,101 individuals eligible to receive the MediKan benefit package as of June 2017.
2. Initiative Description: Under this new initiative, individuals eligible for MediKan will be given a voluntary choice to continue to pursue a Social Security disability determination and be eligible for twelve (12) months of MediKan, or discontinue pursuit of a Social Security disability determination and receive an enhanced Medicaid benefit package with employment support. The goal of this initiative is to provide a comprehensive benefit package to these individuals to (i) divert them from the need for a future disability determination by stabilizing their immediate health care needs and providing Preventive Care, (ii) support their employment pursuits and assist in maintaining employment, and (iii) promote self-sufficiency. The CONTRACTOR(S) is only responsible for individuals selecting to participate in the initiative. The CONTRACTOR(S) is not responsible to provide MediKan benefits to individuals who do not select the option to participate in the initiative.
3. CONTRACTOR(S)’ Responsibilities:
4. The CONTRACTOR(S) shall assess each individual’s needs including medical, Behavioral Health, transportation, housing, work history, work goals, criminal history, etc.
5. The CONTRACTOR(S) shall provide all medically necessary Medicaid benefits as well as additional benefits to address the individual’s needs and promote employment and self-sufficiency.
6. The CONTRACTOR(S) shall contract with community Providers who can address the specific needs of this population and provide the necessary services.
7. The CONTRACTOR(S) shall ensure that the community partners it contracts with have staff trained and certified to provide employment supports and have strong ties with the State’s vocational rehabilitation and workforce systems.
8. The CONTRACTOR(S) may be required to perform choice counseling activities to assist eligible individuals with the decision of whether to participate in the MediKan initiative.

#### Areas of Focus for MediKan Initiatives

1. Describe any relevant experience where the CONTRACTOR(S) worked with a similar population.
2. Describe any relevant experience where the CONTRACTOR(S) contracted with community partners. Include how the CONTRACTOR(S) monitored the community partners and whether or not the community partners provided employment services and connected with the State’s vocational rehabilitation and workforce system.
3. Describe any relevant experience with a population whose socio-economic situation was unstable and impacted their health.
4. Describe the CONTRACTOR(S) relevant experience with providing employment supports. Please include relevant metrics such as, (i) types of services provided, (ii) the number and percent of individuals who became employed, and (iii) the number and percent of individuals who maintained employment after one (1) year.
5. Describe how the CONTRACTOR(S) will evaluate an individual’s needs under this initiative. Please be specific in any evidenced-based practices/models/solutions.
6. Describe how the CONTRACTOR(S) will develop a plan to address the individual’s needs, goals and strategies to achieve those.
7. Describe how the CONTRACTOR(S) would approach choice counseling if asked to provide such services. At a minimum, please include (i) who would provide choice counseling, (ii) training and ongoing education provided to choice counselors, and (iii) how the CONTRACTOR(S) would ensure eligible individuals are provided sufficient information to make an educated choice.
8. Describe how the CONTRACTOR(S) would assess the following individuals and provide services that address the individual’s needs (including but not limited to medical, Behavioral Health, and employment related). Be specific in tools and Providers that would be used including any evidence-based practices adopted and training that was required.
9. Daniel is morbidly obese and has a SUD and a criminal record. He has prior work experience but has been unable to maintain steady employment post incarceration.
10. Anna has severe depression, SUD and an eighth grade education. She has a stated desire to be a veterinarian when asked what type of employment interests her. She has been directed to seek a Social Security disability determination, but is unsure if this is what she wants to pursue.
11. Robert has diabetes and has been unable to maintain stable housing. He often goes long periods of time without the medication he needs. While he has worked with service coordinators in the past, his homelessness has made it difficult to maintain consistent care.
12. Ryan is being discharged from the State Department of Corrections. He has a high-school education and prior work experience. He has been determined eligible for KanCare and has selected the CONTRACTOR(S)’ plan.
13. Linda has schizophrenia and Hepatitis C. She is being discharged from a state hospital.
14. Bill is 56 year old applicant with diabetes, back pain, and moderate depression. The Presumptive Medical Disability Team has determined that he has limitations and likely cannot do more than sedentary work in a setting of low social contact. While this might normally lead to a Medicaid allowance for an applicant of this age, he has a past sedentary work history so would be denied for Medicaid and allowed for MediKan.

### TransMed Employment Opportunity Initiative

#### TransMed Initiative Description

1. TransMed Program: This program provides an additional twelve (12) months of coverage for families who had been Medicaid eligible as Low-Income Families with Children and have lost financial eligibility due to increased earnings. On average there are 5,897 adults receiving Medicaid services under the TransMed program per month. If, during the time they are in TransMed, the adults have a loss of employment or a decrease in earned income they can become eligible for Medicaid again as Low-Income Families with Children.
2. Initiative Description: The State would like to create independence accounts for adults enrolled in TransMed to encourage them to (i) maintain employment, and (ii) transition out of Medicaid and onto the health insurance exchange or other commercial insurance plans. Individuals will be given a voluntary option to either receive TransMed for a twelve (12) month period, or participate in the TransMed initiative. Each individual participating in the TransMed Initiative will have an Independence Account set up in their name. The State would make monthly contributions for a period of time into their Independence Account based on continuing employment starting with the first month of employment until the end the program. At the end of the TransMed eligibility period, individuals would be able to use the funds in the Independence Account for items specified by the State and approved by CMS. Individuals who choose to participate in this initiative will be prohibited from re-enrolling for a period of time determined by the State.
3. CONTRACTOR(S)’ Responsibilities include:
4. The CONTRACTOR(S) shall participate in the initiative and may be required to, among other things, (i) maintain the independence accounts for its Members that are participating in the initiative, (ii) provide training/education for these Members related to commercial insurance and purchasing plans from the exchange, and (iii) assist with transitioning these Members onto commercial insurance.
5. The CONTRACTOR(S) may be required to perform choice counseling activities to assist eligible individuals with the decision of whether to participate in the TransMed initiative.

#### Areas of Focus for TransMed Initiative

1. Describe any relevant experience the CONTRACTOR(S) may have (both in other Medicaid programs and/or with commercial offerings) specific to operating/maintaining independence accounts/health savings accounts/etc.
2. Describe how the CONTRACTOR(S) would operationalize this program – include specific details on how the CONTRACTOR(S) would maintain the independence accounts, and provide the amounts earned in the accounts to Members when their eligibility period ends.
3. Describe how the CONTRACTOR(S) would educate Members on the health insurance market and selecting/purchasing plans from the health insurance exchange and insurance that may be offered by employers.
4. Describe whether the CONTRACTOR(S) would offer a health insurance plan for purchase to these Members once their eligibility period ends.
5. Describe how the independence accounts could be used to promote Social Determinants of Health and Independence and support employment.
6. Describe how the CONTRACTOR(S) would approach choice counseling if asked to provide such services. At a minimum, please include (i) who would provide choice counseling, (ii) training and ongoing education provided to choice counselors, and (iii) how the CONTRACTOR(S) would ensure eligible Members are provided sufficient information to make an educated choice.

### 1915(i) or Other Employment Opportunity Program Initiatives

#### 1915(i) or Other Employment Program Initiative Description

1. Initiative Description: The State is considering pursuing a 1915(i) state plan amendment or 1915(i)-like Waiver to provide members, at their option, a limited set of services to support independence and employment (e.g., employment support services, independent livings skills training, personal assistance, and transportation) to individuals with disabilities or Behavioral Health conditions living and working in the community.
2. CONTRACTOR(S)’ Responsibilities:
3. The CONTRACTOR(S) may be required to assess each eligible individual’s employment and independent living support needs.
4. The CONTRACTOR(S) may be required to provide employment and independent living support services included in the 1915(i)/1915(i)-like Waiver to eligible individuals that address the individual’s needs and promote employment and self-sufficiency.
5. The CONTRACTOR(S) may be required to provide Service Coordination services for Members participating in the initiative.
6. The CONTRACTOR(S) may be required to contract with community Providers who can address the specific needs of this population and provide the necessary services.
7. The CONTRACTOR(S) may be required to perform choice counseling activities to assist eligible individuals with the decision of whether to participate in the 1915(i) initiative.

#### Areas of Focus for 1915(i) or Other Work Program Initiatives

1. Describe any relevant experience with 1915(i) or similar employment programs in other states. Please include relevant metrics such as, (i) types of services provided, and (ii) number of individuals served.
2. Describe any relevant experience where the CONTRACTOR(S) provided employment and/or independent living support services to individuals with disabilities and/or Behavioral Health conditions living and working in the community. Please include relevant metrics such as, (i) types of services provided, (ii) the number and percent of individuals who became employed, and (iii) the number and percent of individuals who maintained employment after one (1) year.
3. Describe how the CONTRACTOR(S) will evaluate an individual’s needs under this initiative. Please be specific in any evidenced-based practices/models/solutions.
4. Describe how the CONTRACTOR(S) will develop a plan to address the individual’s needs, goals and strategies to achieve those under this initiative.
5. Describe how the CONTRACTOR(S) would approach choice counseling if asked to provide such services. At a minimum, please include (i) who would provide choice counseling, (ii) training and ongoing education provided to choice counselors, and (iii) how the CONTRACTOR(S) would ensure eligible individuals are provided sufficient information to make an educated choice.

### Member-Driven Health Care

#### Member-Driven Health Care Initiative Description

1. Initiative Description: The State is interested in promoting Member-driven health care decisions by implementing innovative strategies that support health care quality and cost transparency. The CONTRACTOR(S) shall make healthcare quality and cost information available to Members to help Members identify high quality, high value Providers who can best meet their specific needs.

#### Areas of Focus for Member-Driven Health Care

1. Describe any relevant experience with Member-driven health care initiatives in other states. Please include relevant metrics such as, (i) impact on healthcare quality performance, and (ii) impact on healthcare costs.
2. Provide examples of Member-friendly reports and other materials that can assist Members with selecting high quality, high value Providers who can best meet their specific needs.

### Member Independence Initiatives Reporting Requirements

The CONTRACTOR(S) shall comply with any reporting requirements the State determines are necessary for the Member Independence Initiatives.

## KDHE-DHCF Additional Terms and Conditions

The successful CONTRACTOR(s) shall be required to complete and sign a Business Associate agreement as noted below. The language below is provided for the CONTRACTOR(s) preliminary review. The actual agreement will be provided upon contract award.

## Business Associate Agreement

THIS AGREEMENT is made and entered into by and between the Kansas Department of Health and Environment (hereinafter referred to as “KDHE”) and \_\_\_\_\_\_\_\_\_\_ (hereinafter referred to as “Business Associate”).

Notwithstanding Section V of this Business Associate Agreement (hereinafter referred to as “BAA”), the term of this BAA shall run concurrently with the Underlying Contract between the parties and shall have the same effective date and termination date as the Underlying Agreement.

RECITALS

The Parties to this BAA have a relationship whereby KDHE may provide Business Associate access to Protected Health Information (hereinafter referred to as “PHI”), which may include electronic Protected Health Information, that Business Associate will use to fulfill its contractual obligations to KDHE.

KDHE and Business Associate acknowledge that each party has certain obligations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended, including those provisions of the American Recovery and Reinvestment Act of 2009 (“ARRA”), specifically the Health Information Technology for Economic and Clinical Health Act (“HITECH”), and the statutes implementing regulations to maintain the privacy and security of PHI, and the parties intend this BAA to satisfy those obligations including, without limitation, the requirements of 45 CFR § 164.504(e).

KDHE is a Hybrid Entity under HIPAA, specifically the Division of Health Care Finance within KDHE containing the Covered Entity functions. Therefore Business Associate is not permitted to use or disclose health information in ways that KDHE could not. This protection continues as long as the data is in the hands of Business Associate. Business Associate acknowledges that for the purposes of this BAA, Business Associate is a “business associate” as that term is defined in 45 CFR § 160.103, and therefore the requirements of HIPAA apply to Business Associate in the same manner that they apply to KDHE pursuant to 42 USC § 17931(a).

NOW THEREFORE, in consideration of the mutual promises below and other good and valuable consideration the parties agree as follows:

I. DEFINITIONS

1. “Administrative Safeguards” shall mean the administrative actions, policies and procedures to manage the selection, development, implementation and maintenance of security measures to protect PHI and to manage the conduct of Business Associate’s workforce in relation to the protection of that PHI.
2. “Business Associate” shall have the same meaning as the term “Business Associate” as defined in 45 CFR § 160.103.
3. “Data Aggregation Services” shall mean, with respect to PHI created or received by Business Associate in its capacity as a Business Associate of KDHE, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities, as defined in 45 CFR § 164.501 and as such term may be amended from time to time in this cited regulation.
4. “Designated Record Set” shall mean a group of records maintained by or for KDHE that consists of the following: (a) medical records and billing records about Individuals maintained by or for a health care Provider; (b) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (c) records used in whole or in part, by or for KDHE to make decisions about Individuals. For these purposes, the term “record” means any item, collection, or group of information that includes PHI and is maintained, collected, used, or disseminated by or for KDHE.
5. “Disclosure” shall mean the release, transfer, provision of, access to, or divulging in any other manner of PHI outside the entity holding the information.
6. “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, the implementation regulations promulgated thereunder by the U.S. Department of Health and Human Services, the HITECH (as defined below) and any future regulations promulgated thereunder, all as may be amended from time to time.
7. “HITECH Act” shall mean the Health Information Technology for Economic Clinical Health Act, Title VIII of Division A and Title VI of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L.111-5).
8. “Individual” shall have the same meaning as the term “individual” as defined in 45 CFR § 160.103, and any amendments thereto, and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
9. “Physical Safeguards” shall mean the physical measures, policies and procedures to protect KDHE’s electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion.
10. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR § Part 160 and Part 164.
11. “Protected Health Information” shall have the same meaning as the term “protected health information”, as defined in 45 CFR § 160.103 and any amendments thereto, limited to the information created or received by Business Associate from or on behalf of KDHE.
12. “Required by Law” shall have the same meaning as the term “required by law” in 45 CFR § 164.103.
13. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or his/her designee.
14. “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
15. “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information at 45 CFR § Parts 160, 162 and 164.
16. “Technical Safeguards” shall mean the technology and the policy and procedures for its use that protect PHI and control access to it.
17. “Underlying Contract” means Contract KDHE2018-046 for services between KDHE and or the Kansas State Employees Health Care Commission and Business Associate commencing on August 1, 2017.
18. “Unsecure Protected Health Information (PHI)” means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
19. “Use” shall mean, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within any entity that maintains such information.
20. Capitalized terms used, but not otherwise defined, in this BAA shall have the same meaning ascribed to them in HIPAA, the Privacy Rule, the Security Rule, or HITECH or any future regulations promulgated or guidance issued by the Secretary.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

1. Use and Disclosure. Business Associate agrees to not use or disclose PHI other than as permitted or required by this BAA or as Required by Law.
2. Safeguards to be in Place. Business Associate agrees to use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this BAA. Additionally, Business Associate shall implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of KDHE as required by the Security Rule.
3. HIPAA Training. Business Associate agrees to ensure all members of its workforce, including subcontractor workforce members, which will or potentially will provide services pursuant to the Underlying Agreement will be appropriately trained on the requirements of HIPAA.
4. Duty to Mitigate. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA or the Privacy Rule and to communicate in writing, such procedures to KDHE.
5. Business Associate’s Agents and Subcontractors. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of KDHE agrees, in writing in the form of a Business Associate Agreement, to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information, including implementation of reasonable and appropriate safeguards to protect PHI. Business Associate agrees that it is directly liable for any actions of its subcontractors that results in a violation of this Agreement. Business Associate also agrees to make available to KDHE any contracts or agreements Business Associate has with any subcontractors Business Associate provides PHI under this BAA.
6. Duty to Provide Access. To the extent Business Associate has PHI in a Designated Record Set, Business Associate agrees to provide access, at the request of KDHE, to the PHI in the Designated Record Set to KDHE or, as directed by KDHE, to the Individual, in order to meet the requirements under 45 CFR § 164.524. Any denial by Business Associate of access to PHI shall be the responsibility of, and sufficiently addressed by, Business Associate, including, but not limited to, resolution of all appeals and/or complaints arising therefrom.
7. Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in its possession contained in a Designated Record Set that KDHE directs or agrees to pursuant to 45 CFR § 164.526 at the request of KDHE or an Individual, and within a reasonable time and manner.
8. Duty to Make Internal Practices Available. Business Associate agrees to make its internal practices, books and records, including policies and procedures relating to the use and disclosure of PHI, and any PHI received from, or created or received by Business Associate on behalf of KDHE, available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining KDHE’s compliance with the Privacy Rule.
9. Documenting Disclosures/Accounting. Business Associate agrees to document any disclosures of PHI and information in its possession related to such disclosures as would be required for KDHE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate agrees to provide to KDHE information collected in accordance with Section II(h) of this BAA, to permit KDHE to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
10. Reporting Disclosures to KDHE. In addition to the duty to mitigate under Section II(c), Business Associate agrees to report to KDHE any unauthorized use or disclosure of unsecure PHI not provided for by this BAA or the Privacy Rule of which it or its officers, employees, agents or subcontractors discover, including any breach of unsecure PHI of which it becomes aware, as soon as practicable but no longer than five (5) business days after the discovery of such disclosure. Notice to KDHE shall consist of notifying the KDHE Privacy Officer by phone or email of the occurrence of an unauthorized use, disclosure or security incident.
11. Notification of Breach. Business Associate shall notify Covered Entity within five (5) business days after it, or any of its employees, subcontractors, or agents, discovers that a breach of unsecured PHI as defined by 45 CFR § 164.402 may have occurred, irrespective of any occurrence or non-occurrence of harm. Notice to KDHE shall consist of notifying the KDHE Privacy Officer by phone or email of the occurrence of a Breach or suspected occurrence of a Breach. Business Associate shall exercise reasonable diligence to become aware of whether a breach of unsecured PHI may have occurred and, except as stated to the contrary in this Section, shall otherwise comply with 45 CFR § 164.410 in making the required notification to Covered Entity. Business Associate shall cooperate with Covered Entity in the determination as to whether a breach of unsecured PHI has occurred and whether notification to affected individuals of the breach of unsecured PHI is required by 45 CFR § 164.400 et seq., including continuously providing the Covered Entity with additional information related to the suspected breach as it becomes available. In the event that Covered Entity informs Business Associate that (i) Covered Entity has determined that the affected individuals must be notified because a breach of unsecured PHI has occurred and (ii) Business Associate is in the best position to notify the affected individuals of such breach, Business Associate shall immediately provide the required notice (1) within the time frame defined by 45 CFR § 164.404(b), (2) in a form and containing such information reasonably requested by Covered Entity, (3) containing the content specified in 45 CFR § 164.404(c), and (4) using the method(s) prescribed by 45 CFR § 164.404(d). In addition, in the event that Covered Entity indicates to Business Associate that Covered Entity will make the required notification, Business Associate shall promptly take all other actions reasonably requested by Covered Entity related to the obligation to provide a notification of a breach of unsecured PHI under 45 CFR § 164.400 et seq. Business Associate shall indemnify and hold Covered Entity harmless from all liability, costs, expenses, claims or other damages that Covered Entity, its related corporations, or any of its or their directors, officers, agents, or employees, may sustain as a result of a Business Associate’s breach, or Business Associate’s subcontractor or agent’s breach, of its obligations under this Agreement.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

1. General Use and Disclosure Provision: Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity for the purposes set forth in III (B), if such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity.
2. Specific Use and Disclosure Provisions:
3. Business Associate may use and disclose PHI to perform services for Covered Entity, including specific services, as set out in the Underlying Agreement, and any additional services necessary to carry out those specific services in the Underlying Agreement.
4. Business Associate may use PHI in its possession for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate.
5. Business Associate may disclose PHI in its possession for the proper management and administration of Business Associate, provided that disclosures are required by Law.
6. Business Associate may only de-identify PHI in its possession obtained from Covered Entity with Covered Entity’s prior written consent, in accordance with all de-identification requirements of the Privacy Rule.
7. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1). Covered Entity shall be furnished with a copy of all correspondence sent by Business Associate to a Federal or state authority.
8. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to Covered Entity.
9. Any use or disclosure of PHI by Business Associate shall be in accordance with the minimum necessary policies and procedures of Covered Entity and the regulations and guidance issued by the Secretary on what constitutes the minimum necessary for Business Associate to perform its obligations to Covered Entity under this Agreement and the Underlying Agreement.

IV. OBLIGATIONS OF COVERED ENTITY

1. Covered Entity shall notify Business Associate of any limitation(s) in its Notice of Privacy Practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate’s use or disclosure of PHI.
2. Covered Entity shall notify Business Associate in a timely manner of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such change may affect Business Associate’s permitted or required use or disclosure of PHI.
3. Covered Entity shall notify Business Associate in a timely manner of any restriction to the use and/or disclosure of PHI, which the Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.
4. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

V. TERMINATION

1. Term. The term of this Agreement shall run concurrently with the Underlying Contract with Covered Entity and shall terminate upon termination of the Underlying Contract and when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions of Section (V)(c)(2).
2. Termination for Cause. Upon either party’s knowledge of a material breach by the other party, such party shall either:
3. Provide an opportunity for the breaching party to cure the breach, end the violation, or terminate this Agreement if the breaching party does not cure the breach or end the violation within five (5) business days.
4. Immediately terminate the Agreement if the breaching party has breached a material term of this Agreement and cure is not possible.
5. If neither termination nor cure is feasible, the non-breaching party shall report the violation to the Secretary.
6. Effect of Termination.
7. Except as provided in paragraph V(c)(2) of this Agreement, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
8. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification in writing of the conditions that make return or destruction infeasible. Upon verification that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If it is infeasible for Business Associate to obtain, from a subcontractor or agent, any PHI in the possession of the subcontractor or agent, Business Associate must provide a written explanation to Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors’ and/or agents’ use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.
9. Judicial or Administrative Proceedings. Notwithstanding any other provision herein, Covered Entity may terminate the applicable Underlying Agreement, effective immediately, upon a finding or stipulation that Business Associate violated any applicable standard or requirement of the Privacy Rule or the Security Rule or any other applicable laws related to the security or privacy of PHI, relating to the Underlying Agreement, in any criminal, administrative or civil proceeding in which the Business Associate is a named party.

VI. MISCELLANEOUS

1. Regulatory References. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended and for which compliance is required.
2. Amendment. No change, amendment, or modification of this Agreement shall be valid unless set forth in writing and agreed to by both parties, except as set forth in Section VI(l) below.
3. Indemnification. Subject to the terms of the underlying CONTRACT, Business Associate shall indemnify Covered Entity for any and all claims, inquiries, costs or damages, including but not limited to any monetary penalties, that Covered Entity incurs arising from a violation by Business Associate, or a subcontractor or agent of Business Associate, of its obligations hereunder.
4. Survival. The respective obligations of Business Associate under this Agreement shall survive the termination of this Agreement.
5. Interpretation. Any ambiguity or inconsistency in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule, the Security Rule, and the ARRA.
6. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity and its respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
7. Notices. Any notices to be given to either party under this Agreement shall be made in writing and delivered via email at the address given below:

Business Associate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covered Entity: Brian Vazquez, Brian.Vazquez@ks.gov

1. Headings. The section headings are for convenience only and shall not be construed to define, modify, expand, or limit the terms and provisions of this Agreement.
2. Governing Law and Venue. This Agreement shall be governed by, and interpreted in accordance with, the internal laws of the State of Kansas, without giving effect to its conflict of law provisions.
3. Binding Effect. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns.
4. Effect on Underlying Agreement. If any portion of this Agreement is inconsistent with the terms of the Underlying Agreement, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.
5. Modification. The parties acknowledge that state and Federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to ensure compliance with such developments. The parties specifically agree to take such action as may be necessary to implement the standards and requirements of HIPAA and other applicable state and Federal laws relating to the security or confidentiality of PHI as determined solely by Covered Entity.

In the event that a Federal or State law, statute, regulation, regulatory interpretation or court/agency determination materially affects this Agreement, as is solely determined by Covered Entity, the parties agree to negotiate in good faith any necessary or appropriate revisions to this Agreement. If the parties are unable to reach an agreement concerning such revisions within the earlier of sixty (60) days after the date of notice seeking negotiations or the effective date of the change in law or regulation, or if the change in law or regulation is effective immediately, the Covered Entity, in its sole discretion, may unilaterally amend this Agreement to comply with the change in law upon written notice to Business Associate.

VII. OBLIGATIONS OF BUSINESS ASSOCIATE PURSUANT TO HITECH

1. Access to PHI in an Electronic Format. If Business Associate uses or maintains PHI in an Electronic Health Record, Business Associate must provide access to such information in an electronic format if so requested by an Individual. Any fee that Business Associate may charge for such electronic copy shall not be greater than Business Associate’s labor costs in responding to the request. If an Individual makes a direct request to Business Associate for access to a copy of PHI, Business Associate will promptly inform the Covered Entity in writing of such request.
2. Prohibition on Marketing Activities. Business Associate shall not engage in any marketing activities or communications with any individual unless such marketing activities or communications are allowed by the terms of the Underlying Agreement and are made in accordance with HITECH or any future regulations promulgated thereunder. Notwithstanding the foregoing, any payment for marketing activities should be in accordance with HITECH or any future regulations promulgated thereunder.
3. Application of the Security Rule to Business Associate. Business Associate shall abide by the provisions of the Security Rule and use all appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Without limiting the generality of the foregoing sentence, Business Associate shall:
4. Adopt written policies and procedures to implement the same administrative, physical, and technical safeguards required of the Covered Entity.
5. Abide by the most current guidance on the most effective and appropriate technical safeguards as issued by the Secretary.
6. If Business Associate violates the Security Rule, it acknowledges that it is directly subject to civil and criminal penalties.

VIII. ADDITIONAL OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate shall not receive any remuneration, directly or indirectly, in exchange for any PHI, unless so allowed by the terms of the Underlying Agreement and in accordance with HITECH and any future regulations promulgated thereunder.

IX. ENFORCEMENT

Business Associate acknowledges that, in the event it, or its subcontractor or agent, violates any applicable provision of the Security Rule or any term of this Agreement that would constitute a violation of the Privacy Rule, Business Associate will be subject to and will be directly liable for any and all civil and criminal penalties that may result from such violation.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have executed this Agreement as of the date reflected below.

Kansas Department of Health and Environment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Susan Mosier, MD, MBA, FACS Date

Secretary and State Health Officer

Business Associate:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Insert MCO CEO] Date

By submission of a proposal potential CONTRACTOR(s) are confirming compliance with the following federal requirements.

## Compliance with the “Pilot Program for Enhancement of Contractor Employee Whistleblower Protections”

Congress has enacted a law, found at 41 U.S.C. 4712, that encourage employees to report Fraud, Waste, or Abuse. This law applies to all employees working for CONTRACTOR(S), grantees, subcontractors and sub grantees on Federal grants and contracts [for the purpose of this document, “Recipient of Funds”]. The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) mandates a pilot program entitled, "PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS".

This program requires all grantees, their sub grantees and subcontractors to:

1. Inform their employees working on any Federal award they are subject to the whistleblower rights and remedies of the pilot program.
2. Inform their employees in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce.
3. CONTRACTOR(S) and grantees will include such requirements in any agreement made with a subcontractor or sub grantee.

Employees of a CONTRACTOR, subcontractor, grantee [or sub grantee] may not be discharged, demoted, or otherwise discriminated against as reprisal for ''whistleblowing." In addition, whistleblower protections cannot be waived by any agreement, policy, form or condition of employment.

Whistleblowing is defined as making a disclosure "that the employee reasonably believes is evidence of any of the following:

1. Gross mismanagement of a Federal contract or grant.
2. A gross waste of Federal funds.
3. An abuse of authority relating to a Federal contract or grant.
4. A substantial and specific danger to public health or safety.
5. A violation of law, rule, or regulation related to a Federal contract or grant (including the competition for, or negotiation of, a contract or grant).
6. To qualify under the statute, the employee's disclosure must be made to:
7. A Member of Congress or a representative of a Congressional committee.
8. An Inspector General.
9. The Government Accountability Office.
10. A Federal employee responsible for contract or grant oversight or management at the relevant agency.
11. An official from the Department of Justice, or other law enforcement agency.
12. A court or grand jury.
13. A management official or other employee of the CONTRACTOR, subcontractor, grantee, or sub grantee who has the responsibility to investigate, discover, or address misconduct.

The requirement to comply with, and inform all employees of, the "Pilot Program for Enhancement of CONTRACTOR(S) Employee Whistleblower Protections" is in effect for all grants contracts, sub grants, and subcontracts through January 1, 2017.

The Recipient of Funds acknowledges that as a condition of receiving funds, it has complied with the terms of the "PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS", and has informed its employees in writing and in the predominant native language of the workforce, that by working on any Federal award, the employees are subject to the whistleblower rights and remedies of the pilot program.

NON-DEBARMENT CERTIFICATION AND WARRANTY

The Recipient of Funds acknowledges that KDHE is required to verify that the Recipient of Funds has not been suspended, debarred or otherwise excluded from receiving Federal funds. Verification may be accomplished by (i) checking the Excluded Parties List System (EPLS) maintained by the General Services Administration; (ii) obtaining a certification from the entity; or (iii) by adding a clause or condition to the transaction.

The Recipient of Funds, as a condition of receiving funds, certifies and warrants that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or by any department or agency of the State of Kansas.

## Information Requirements

If the CONTRACTOR(S) elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, then consistent with 42 CFR § 438.10 CONTRACTOR(S) must furnish information about the services it does not cover as follows:

1. To the State whenever it adopts the policy during the term of the CONTRACT;
2. To potential Members before and during enrollment; and
3. To Members within ninety (90) days after adopting the policy with respect to any particular service.

## Retention of Records

Unless the State specifies in writing a different period of time, the CONTRACTOR(S), and any Subcontractor(s), agrees to preserve and make available at reasonable times all of its books, documents, papers, records and other evidence involving transactions related to this CONTRACT for a period of no less than ten (10) years from the date of the expiration or termination of this CONTRACT.

Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds five (5) years.

The CONTRACTOR(S), and any Subcontractor(s), agrees that authorized Federal and State representatives, including but not limited to, personnel of the using agency; independent auditors acting on behalf of state and/or Federal agencies shall have access to and the right to examine records and access the physical premises of the CONTRACTOR(S), and any Subcontractor(s), during the CONTRACT period, and during the ten (10) years post CONTRACT period or ten (10) years from the date of completion of any audit, whichever is later. Delivery of and access to the records shall be within five (5) business days at no cost to the State.

## Off-Shore Sourcing

If, during the term of the CONTRACT, the CONTRACTOR(S) or Subcontractor(s) plans to move work previously performed in the United States to a location outside of the United States, the Subcontractor(s) shall immediately notify the Procurement and Contracts and the respective agency in writing, indicating the desired new location, the nature of the work to be moved and the percentage of work that would be relocated. The Director of Purchases, with the advice of the respective agency, must approve any changes prior to work being relocated. Failure to obtain the Director's approval may be grounds to terminate the CONTRACT for cause. At all times during the CONTRACT period, the CONTRACTOR(S) must remain in the United States. Any claims paid by the CONTRACTOR(S) to a Participating Provider, Non-Participating Provider, Subcontractor(s), or financial institution located outside of the United States must be excluded from base data used in the development of Actuarially Sound Capitation Rates.

## Termination at Expiration and/or Termination of Contract

1. A transition period shall begin in the event of termination of this Contract, prior to the end of the term of this Contract if the State and the CONTRACTOR(S) do not execute a new Contract or upon notice that the State does not intend to exercise an option to renew this Contract for any additional year. During the transition period, the CONTRACTOR(S) must work cooperatively with the State and any MCO with whom the State may contract for similar services. The State will specify a plan for the CONTRACTOR(S) to follow during this transition period. The length of the transition period shall, in the State’s sole discretion be no less than three (3) months but no more than six (6) months in duration. The costs relating to the transfer of materials and responsibilities must be paid by the CONTRACTOR(S) without additional compensation or reimbursement of expenses from the State. The CONTRACTOR(S) must be responsible for the provision of necessary information to the State and any MCO during the transition period to ensure a smooth transition of responsibility, including but not limited to, Prior Authorized Covered Services to the Member’s new MCO and comply fully and timely with the new MCO’s requests for historical utilization data including the Member Plans of Service and Person-Centered Service Plans for Service Coordination. The CONRACTOR(S) shall abide by transitions in care requirements as set forth in Section 5.4.12 of this Contract.

## 5.27. Post-Contract Obligations and Procedures

1. Contract termination shall not extinguish or prejudice the State’s right to enforce its rights and remedies under this Contract or State and Federal law and regulation, including but not limited to the right to recover damages for breach of contract.
2. Continuing obligations: Termination or expiration of this Contract shall not discharge the CONTRACTOR(S) of obligations with respect to services or items furnished prior to termination or expiration, including retention of records and verification of overpayments or underpayments. Termination or expiration shall not discharge the State’s payment obligations, as allowed by law, to the CONTRACTOR(S) or the CONTRACTOR(S)' payment obligations to its Subcontractors and Providers with respect to Covered Services furnished prior to termination or expiration. Upon any termination or expiration of this Contract, in accordance with the provisions in this section, the CONTRACTOR(S) must:
3. Provide the State with any and all information deemed necessary by the State within thirty (30) Calendar Days of the request;
4. Be financially responsible for Claims with dates of service through 11:59 p.m. Central time on the day of termination, except as otherwise provided in this section of the Contract, including those submitted within established time limits after the day of termination;
5. Be financially responsible for hospitalized patients through the date of discharge or fifteen (15) Calendar Days after termination or expiration of this Contract, whichever is earlier;
6. Be financially responsible for the results of Member Appeals of Adverse Benefit Determinations rendered by the CONTRACTOR(S) concerning treatment or services requested prior to termination or expiration that would have been provided but for the denial prior to termination or expiration, which are subsequently overturned at a Grievance, Appeal or State Fair Hearing proceeding;
7. Arrange for the orderly transfer of patient care and patient records to those Providers who will be assuming care for the Member, in accordance with Section 11 of this Contract; and
8. Maintain the confidentiality of all Member’s protected health information (PHI) as required by law and the provisions of this Contract.
9. Notice to Members: In the event that this Contract is terminated or expires without the State and the CONTRACTOR(S) executing a new contract, the CONTRACTOR(S) must notify all Members in writing of such termination or such expiration at least thirty (30) Calendar Days in advance of the effective date of termination or expiration. Notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for Members with limited English proficiency. For Members who are undergoing treatment for an Acute condition, the CONTRACTOR(S) must describe in the notice the process for obtaining a complete transition of care plan in accordance with Section 5.4 of this Contract to ensure the continuation of care prior to termination or expiration of this Contract.
10. Termination or expiration requirements: The CONTRACTOR(S) must provide the State with all outstanding Encounter data. If the State or the CONTRACTOR(S) provides written notice of termination or expiration, ten percent (10%) of one month's Capitation Payment due to the CONTRACTOR(S) will be withheld. Once the State determines that the Contractor has substantially complied with the termination or expiration requirements in this section, the withheld portion of the Capitation Payment will be paid to the CONTRACTOR(S). The State will not unreasonably delay or deny a determination that the CONTRACTOR(S) substantially complied with the termination or expiration requirements. The State will share with the CONTRACTOR(S) a determination on compliance with the termination or expiration requirements by the first (1st) day of the fifth (5th) month after the Contract ends. If the State determines that the CONTRACTOR(S) has not substantially complied, the State will share a subsequent determination by the first (1st) day of each subsequent month. If the State subsequently determines that the CONTRACTOR(S) has substantially complied with termination or expiration requirements, it will promptly pay the withheld portion of the Capitation Payment.

# 6. RFP Purpose, CONTRACTOR(S)’ Duties, Implementation and General Administrative Information

## RFP Purpose

The State of Kansas is issuing this RFP to obtain competitive responses from CONTRACTOR(S) to provide managed care for the Kansas Medicaid and CHIP programs. Services included in this RFP are physical health services, Behavioral Health services, and LTSS, including NF care and HCBS. These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and SUD services including existing 1915(c) HCBS Waiver programs for children with a SED and six other 1915(c) HCBS Waiver populations. Statewide contracts will be awarded to winning CONTRACTOR(S).

Almost all Medicaid beneficiaries and 100% of CHIP beneficiaries will be required to enroll in a managed care plan.

The State intends to improve upon an already recognized innovative managed care program. Requirements in this RFP are extensive, reflecting the ambitious nature of this program. The State recognizes that CONTRACTOR(S) will bring a variety of strengths, experience, innovation, and added value to the KanCare program, all of which will be considered in the selection. The State encourages and solicits the widest-possible range of responses to this RFP. The State is interested in developing a vibrant business relationship with its CONTRACTOR(S) to help identify, define, and implement a continuing series of market reforms which lead to optimal integration of care.

## CONTRACTOR(S) Responsibilities

The selected CONTRACTOR(S) shall be responsible for duties and activities that include but are not limited to:

1. Federal and State Laws and Regulations: The CONTRACTOR(S) shall observe and comply at all times with all, then current, Federal and State Laws and Regulations related to or affecting this CONTRACT during the term of this CONTRACT. This includes existing laws and regulations as well as any laws and regulations that may be enacted during the term of this CONTRACT. It is the CONTRACTOR(S)’ responsibility to remain aware of changes in existing Federal and State Laws and Regulations as well as the enactment of new Laws and Regulations as they affect the CONTRACTOR(S)’ duties and responsibilities under this CONTRACT.

The remaining terms and conditions of the CONTRACT shall remain unchanged.

1. The CONTRACTOR(S) will demonstrate a significant improvement in core health and life satisfaction Outcomes for the people served in these programs over the full term of this CONTRACT. Savings realized by the program should be achieved by increased Service Coordination and better Outcomes (e.g. NOMS, HEDIS, and others) rather than by significant or widespread reduction in rates to Providers, by withholding required services, or by decreasing quality of or access to any services.
2. The CONTRACTOR(S) selected for this work will need to demonstrate:
3. How they will work with existing CMHCs and the Community Developmental Disability Organizations (CDDOs) across Kansas, and how they will incorporate the functions of the CMHCs and CDDOs to the extent required by law.
4. How they will minimize potential conflict of interest between assessment of need for services and service delivery.
5. How they will establish a comprehensive, accessible Provider network that offers a choice of Provider to the extent possible and appropriate and a coordinated array of services to Members.
6. How they will add additional Provider network as necessary to successfully meet the needs of people with mental health, SUD, PD, DD, TBI, technology assisted (TA), autism, and FE Waiver service needs.
7. How they will facilitate the growth of relationship-centered models that ensure a maximum number of people have the option of using as their medical home, a relationship-centered model of care that also has specialized or non-traditional Providers with knowledge about/experience with the person’s treatment needs and/or a relationship with the person.
8. How they will manage nearly all statewide physical, Behavioral Health services, LTSS and HCBS services for Kansas residents who meet the eligibility requirements defined in this CONTRACT.
9. How they will apply managed care practices in a manner that results in eligible individuals receiving services that are timely, culturally relevant, and effective in reducing problems and symptoms stemming from physical or Behavioral Health issues, maximizing functioning, and improving the recipient’s quality of life
10. How they will operate in partnership with the State and the community to ensure that managed care operations and services result in the delivery of effective services that sustain individual functional gains. The CONTRACTOR(S) shall routinely solicit input from stakeholders, including individuals and families of Members receiving services that inform the CONTRACTOR(S) about needed system improvements.
11. How they will be proactive and bring innovative plans to organize and administer a service delivery system that meets the needs of beneficiaries, and addresses Social Determinants of Health and Independence, while complying with all Federal and State laws, regulatory and contractual requirements.
12. How they will ensure the delivery of services to Members that are readily accessible and provided in the least restrictive, safe environment likely to result in desired Outcomes.
13. How they will ensure the delivery of services to all areas of the State, ensuring access in rural and remote areas as well as urban areas.
14. How they will conduct managed care activities including, but not limited to, Provider network development and management, access to care, customer service, Service Coordination, UM, QM, and effective resolution of complaints, and Grievances, Reconsiderations and Appeals.
15. How they will make data-based decisions that positively impact the delivery system.
16. How they will operate in a manner that promotes efficiency in the service delivery system while offering the highest quality services.
17. CONTRACTOR(S) shall provide a managed care process that does not add to the administrative burden for Providers.
18. Provide their recommendations to reduce administrative burdens on beneficiaries and Providers. The State will consider administrative simplification recommendations even if they might require Waiver or special consideration/approval from CMS. Such recommendations could include proposals to:

Reduce or simplify Provider credentialing requirements

Simplify or streamline claims processing for Providers

Simplify or streamline PA processes

1. In accordance with 42 CFR § 438.905(a), CONTRACTOR(S) must comply with all Federal regulations and guidance pertaining to parity in mental health and substance use disorder benefits, including:
2. If the CONTRACTOR(S) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Members, the CONTRACTOR(S) may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.
3. If the CONTRACTOR(S) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to Members, the CONTRACTOR(S) must either apply the aggregate lifetime or annual dollar limit to both the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.
4. If the CONTRACTOR(S) includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to Members through a contract with the state, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits
5. The CONTRACTOR(S) must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by the same CONTRACTOR).
6. If a Member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Member in every classification in which medical/surgical benefits are provided.
7. CONTRACTOR(S) may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, and prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.
8. CONTRACTOR(S) may not impose non-quantitative treatment limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.
9. CONTRACTOR(S) must provide documentation and reporting to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in a format and frequency as specified by the State.

## State Agencies and Programs

The Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DHCF) - The vision of KDHE-DHCF is “healthy Kansans living in safe and sustainable environments.” As part of that vision, The KDHE-DHCF is the State agency responsible for developing and coordinating health policy in the State of Kansas. KDHE-DHCF is the single state Medicaid agency and also administers both the CHIP and the State Employee Health Plan. KDHE-DHCF was created on July 1, 2011, pursuant to Executive Reorganization Order No. 38. Prior to this date, Medicaid and CHIP were functions of the Kansas Health Policy Authority. As the single state Medicaid and CHIP agency, KDHE-DHCF is responsible for administration and supervision of these programs. KDHE-DHCF, other state agencies, as well as many CONTRACTOR(S) to carry out the required duties of these programs. Responsibility for Medicaid and CHIP eligibility determination in Kansas resides with KDHE-DHCF. The overall management of the CONTRACTOR(S) selected for this work will be accomplished by the KDHE-DHCF.

The following mission statement is the guiding framework of KDHE-DHCF:

***“To develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Division are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs.”***

More information about KDHE can be found at: <http://www.kdheks.gov/>

Additional information about KDHE-DHCF can be found at: <http://www.kdheks.gov/hcf>

The Kansas Department for Aging and Disability Services (KDADS) is a cabinet level agency, which promotes the right care, at the time, at the right place. The Department is also responsible for the oversight of community programs and HCBS, 1915(c) Waivers, Adult Care Homes and Behavioral Health programs.

More Information about KDADS can be found at: <http://www.kdads.ks.gov>

1. Current Kansas Medicaid and Children’s Health Insurance Programs: KDHE-DHCF administers KanCare and a small FFS program including over 20 individual medical assistance programs, serving over 403,000 Kansans annually. Programs include Medicaid, CHIP, and several state funded programs.
2. Program and Policy: All Medicaid beneficiaries, except American Indians/Alaska Natives who opt out, Medicare beneficiaries who are covered only under a Medicare savings program, ineligible non-citizens receiving emergency services under the Sixth Omnibus Budget Reconciliation Act (SOBRA) and retroactive-only services are included in this RFP. Kansas covers both mandatory and non-mandatory groups. Kansas Medical programs can be divided into four general groups:
3. Medicaid – Elderly and Disabled/Supplemental Security Income (SSI) Based Programs: Provides coverage to persons age 65 and older or who are determined to meet Social Security disability or blindness requirements, including those determined disabled through the Presumptive Medical Disability Determination (PMDD) process. Programs include Medicare Savings Plans, Medically Needy, SSI recipients, Working Healthy, and persons in LTSS. Most groups include a resource test and an income test.
4. Medicaid – Children and Families Programs: Provides coverage to children, pregnant women, and caretakers. Programs include Caretaker Medical, Transitional Medical, Poverty Level Pregnant Women (PW), and child medical. An income test applies, but resources are not applicable to these groups.
5. Children’s Health Insurance Program – Title XXI (CHIP): CHIP provides coverage to children under age 19. Families may be responsible for a monthly premium, depending on income and household size.
6. Specified eligibility policies, procedures and other information can be found on the KDHE website: <http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy>.
7. Additional information regarding Child Welfare Programs is provided in The Children and Family Services Policy and Procedure Manual (Child Welfare Programs) at <http://www.dcf.ks.gov/services/PPS/Pages/PPSpolicies.aspx>.

## CONTRACTOR(S)’ Proposals

1. CONTRACTOR(S)’ activities under this proposal and subsequent CONTRACT must be consistent with the following State initiatives, which may expand over time:
2. Provide holistic care focused on Outcomes.
3. Create a strong safety net for our most vulnerable Kansans.
4. Improve efficiencies in the delivery of health care.
5. Assist Medicaid Members to greater independence.
6. Reward personal responsibility for health Outcomes.
7. Increase use of preventive services.
8. Reduce the number of Critical Incidents.
9. Improve stability for children in foster care.
10. Increase collaboration with community-based organizations to connect Members to housing, food insecurity, employment, education and other Social Determinants6 of Health and Independence.
11. Increase accountability in business practices, decreasing potential for conflict of interest, and decreasing Fraud, Waste, or Abuse.
12. Increase access to and successful maintenance of competitive integrated employment.
13. Improve and redesign Service Coordination to improve Member health Outcomes.

## Categories of Eligibility

The expectation of the State is that almost all Medicaid and all CHIP beneficiaries will be covered in the comprehensive, capitated, risk-based managed care CONTRACT. Populations served in Kansas Medical Assistance Programs are detailed in the current Special Terms and Conditions document.

1. Beneficiaries eligible for managed care include:
2. Adults and children eligible under the Caretaker Medical program
3. Certain pregnant women and children through the month of their first (1st) birthday
4. Certain children over the age of one (1) year and through the month of their sixth (6th) birthday
5. Certain children over the age of six (6) and through the month of their twenty-first (21st) birthday
6. Children under the age of nineteen years who are not eligible for Medicaid, but are living in families with incomes less than 241% of the Federal poverty level (CHIP)
7. Aged and disabled individuals receiving Supplemental Security Income (SSI)
8. Medically needy aged and disabled individuals (spenddown populations)
9. Employed persons with disabilities receiving coverage under the Medicaid Buy-in (Working Healthy)
10. Children in foster care
11. Children whose families receive adoption support
12. Beneficiaries receiving long-term care – including institutional care, HCBS and Money Follows the Person
13. Beneficiaries who are not eligible for managed care include:
14. Beneficiaries receiving state-funded assistance: MediKan, TB, State-Only institutional care
15. Ineligible non-citizens receiving time-limited coverage of certain emergency medical conditions (SOBRA)
16. Beneficiaries who have an eligibility period that is only retroactive
17. Persons whose only coverage is under a Medicare Savings Program
18. Persons enrolled in PACE

## General and Administrative Information

A discussion of general and administrative information items follows.

1. Mandatory Qualifications:
2. The CONTRACTOR(S) will coordinate, integrate, and be accountable for all services proposed. This excludes an arrangement between CONTRACTOR(S) of joint venturing or joint response to this RFP as such arrangements will not be allowed. Generally the CONTRACTOR(S) may only appear in one proposal submitted in response to this RFP. Multiple submissions from a firm that is a CONTRACTOR(S) in a proposal or submission of alternative proposals will be grounds for disqualification of such proposals. At the sole discretion of the State, submitting multiple proposals in different forms may result in the disqualification of all CONTRACTOR(S) knowingly involved.
3. The CONTRACTOR(S) or a proposed subcontractor must be experienced in the business of furnishing Medicaid and CHIP capitated Covered Services comparable in size and complexity to that specified herein. CONTRACTOR(S) may be required to furnish information supporting the capability to comply with conditions for bidding and fulfill the CONTRACT if receiving an award of CONTRACT. Such information may include, but shall not be limited to, a list of similar size and type CONTRACTS the CONTRACTOR(S) has completed.
4. Managed Care Services (MCS) Procurement Schedule:

The following procurement schedule represents the State's best estimate of the anticipated schedule that will be followed. Unless otherwise specified, the time of day for the following events will be between 8:00 a.m. and 5:00 p.m. Central Standard Time.

|  |  |  |
| --- | --- | --- |
| **MCS PROCUREMENT SCHEDULE**  NOTICE: The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. | | |
| **EVENT** | | **DATE** |
| 1. | State Releases MCS RFP | November 2, 2017 |
| 2. | Deadline for Submitting Written Questions Requesting Clarifications | November 13, 2017 by 12PM CST |
| 3. | Pre-Bid CONTRACTOR Conference (Not Mandatory) | November 20, 2017 9AM CST |
| 4. | State will post an amendment with bidder questions and agency answers | TBD |
| 5. | Deadline for Submitting Follow-up Written Questions Requesting Clarifications | TBD |
| 6. | Deadline for State to Post Final Responses to Follow-up Written Questions | TBD |
| 7. | Proposal Submission Deadline (RFP Closing Date) | **January 5, 2018 by 2pm CST** |
| 8. | Evaluation of Bids Conducted by State | TBD |
| 9. | Face-to-Face Negotiations with Selected CONTRACTOR(S) | TBD |
| 10. | Previous MCO Contracts Expire | December 31, 2018 |
| 11. | New Contracts take Effect and Services Rendered Under New CONTRACT(S) | January 1, 2019 |

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Timeline between the RFP Closing Date and the expiration of the previous Contracts will be completed and issued with the first addendum to this RFP.

1. Explanation of MCS Procurement Schedule and Process:
2. After studying this RFP document, CONTRACTOR(S) considering bidding are encouraged to submit questions to clarify any ambiguity in the RFP and attend the Pre-Bid CONTRACTOR Conference on Monday, November 20, 2017 at 9AM CST.
3. After the CONTRACTOR(S) submits their proposals, the State Evaluation Committee will conduct an evaluation of all proposals received. A revised timeline will be issued detailing the procurement schedule between the RFP closing date and the old contract’s expiration. The result of this first round of proposal evaluations is the invitation of selected CONTRACTOR(S) to appear before the Procurement Negotiating Committee (PNC) and the State Evaluation Committee for negotiations, demonstrations, and/or Discovery Sessions. The exact nature of these demonstrations and/or sessions will be specified in the invitation. Appearance before the PNC is discussed in RFP Section 1.5.
4. After the Negotiations, Demonstrations, and Discovery Sessions are completed, selected CONTRACTOR(S) may be asked to participate in negotiations leading to a Revised Offer. After the State issues the Call for Revised Offers, selected CONTRACTOR(S) will then submit their Revised Offers for evaluation.
5. After evaluation of the Revised Offers, the State Evaluation Committee will review their evaluations with the PNC. After reviewing the evaluations from the Evaluation Committee, the PNC may seek additional information, conduct additional negotiations, or other activities. The PNC may select a CONTRACTOR(S) with which to discuss additional and final CONTRACT terms. All CONTRACT terms must be final and CONTRACTOR(S) commitment to executing such CONTRACT shall be unquestionably demonstrated for the PNC to consider awarding the CONTRACT to the CONTRACTOR. If the PNC finds the final CONTRACT terms acceptable, then a Notice of Intent to Award may be issued. If the PNC does not find the final CONTRACT terms acceptable, then the PNC may discuss final terms with other CONTRACTOR(S). Once a Notice of Intent to Award has been issued, the CONTRACTOR(S) shall execute the final CONTRACT. Failure to do so in a timely manner may result in the rejection of the CONTRACTOR(S), and the CONTRACT being issued to another CONTRACTOR.
6. After the CONTRACT is executed and approved by CMS, the CONTRACTOR(S) will work with State personnel and the State’s Fiscal Agent to implement Contracts.
7. Disability Accommodation Request:
8. Any attendee of the Pre-Bid CONTRACTOR(S) Conference or attendee of any other meeting in the procurement process, with a disability, may request accommodation in order to participate. Requests for accommodation should be made to the Procurement Officer at least five (5) business days in advance of the meeting.
9. Accessible Technology:
10. Computer Hardware, Software, Other Technologies: All products and services provided or developed as part of fulfilling this CONTRACT shall conform to Section 508 of the Rehabilitation Act of 1973 and any amendments thereto, (29 U.S.C. & 794d), and its implementing Electronic and Information Technology Accessibility Standards (36 CFR § 1194). Section 508 requires that electronic and information technology is accessible to people with disabilities, including employees and Beneficiaries of the public.

Information regarding accessibility under Section 508 is available at: <http://www.section508.gov/>

Section 508 Guidance Documents can be found at: <https://www.section508.gov/content/guidance>

1. Web Development: Websites, web services, and web applications shall be accessible to and usable by individuals with disabilities. This means that any websites, web services, and/or web applications developed in the fulfillment of this CONTRACT — including but not limited to: ((a) any web-based training material, user documentation, reference material, or other communications materials intended for public or internal use related to the work completed under this CONTRACT; and (b) any updates, new releases, versions, upgrades, improvements, bug fixes, patches, customizations, or other modifications to the above — shall comply with Kansas Information Technology Policy 1210: State of Kansas Web Accessibility Requirements (IT Policy 1210), IT Policy 1210 is located at: <http://oits.ks.gov/kito/itec/itec-policies/itec-policy-1210>.
2. For additional reference, supporting information for implementing IT Policy 1210 can be found at: <http://da.ks.gov/kpat/resources/>.
3. Affirmation of Conformance:

The CONTRACTOR(S) shall provide a description of conformance with the above mentioned specifications by means of a completed Voluntary Product Accessibility Template (VPAT) or other comparable document. VPAT information and the latest version of the VPAT template is available at: http://www.itic.org/policy/accessibility/

A VPAT is only necessary when the CONTRACTOR(S) is using pre-existing (off the shelf) software. This conformance claim becomes a contractual term between the CONTRACTOR(S) and the contracting state agency.

1. News Releases:
2. Only the State is authorized to issue news releases relating to this RFP, its evaluation, award, and/or performance of the CONTRACT.
3. Commercial Advertising:
4. The CONTRACTOR(S) shall not refer to this RFP, its evaluation, award, or the CONTRACTOR(S)’ performance under the CONTRACT in any commercial advertising media without the approval of the State. The State may withhold approval for any reason.

## Attachments, Exhibits and URL Links

Below is a list of Attachments and Exhibits related to the KanCare program:

| **Attachment** | **Name** |
| --- | --- |
| A | Definitions and Acronyms |
| B | HCBS Waivers |
| C | Services |
| D | Grievances, Appeals, Reconsiderations and State Fair Hearings |
| E | Health Risk Assessment (HRA) Questions |
| F | KDHE Recommended HRA Scoring |
| G | Liquidated Damages |
| H | Reports |
| I | Claims and Encounter Processing |
| J | Encounter Data and Other Data Requirements |
| K | Service Coordination Workflow |
| L | Service Coordination Roles and Responsibilities Matrix |

1. Attachments, Exhibits, and Universal/Uniform Resource Locator (URL) Links
2. Attachments:

The instructions, information, deliverables and other provisions as applicable found in Attachments A through L shall be incorporated into the CONTRACT award and made a part thereof. EVT0005464 can be found at the following address: <http://admin.ks.gov/offices/procurement-and-contracts/bid-solicitations>

1. KanCare Bidder’s Library

Some of the information provided in the Bidder’s Library is for informational purposes only. Such information is typically historical or illustrative in nature. These documents shall not be incorporated into the CONTRACT award and made a part thereof.

Documentation related to policy, guides, templates, waivers and tools to serve KanCare members shall be incorporated into the contract and made a part thereof.

A Bidder’s Library has been set up for potential bidders which contains information in regards to policies and other information necessary to assist bidders in the preparation of their proposals.  Bidders must follow the process outlined below in order to gain access to the KanCare 2.0 Bidder’s Library:

Email Aubrey Waters at [aubrey.waters@ks.gov](mailto:aubrey.waters@ks.gov) requesting access and include the following information:

* Name of individual making request
* Name of Organization
* Email address of individual or organization making the request

1. Federal and State Laws and Regulations:

The State has elected to NOT PROVIDE copies of Federal and State Laws and Regulations. Certain legal or regulatory citations have been provided either as required by law or regulation or in the interest of facilitating the CONTRACTOR(S) awareness of the citations. It is the CONTRACTOR(S) responsibility to remain aware of applicable laws and regulations and to remain compliant with them as required by the Terms and Conditions of this RFP.

1. Kansas Statutes and Regulations can be found at:

<http://www.kslegislature.org/li/statute/>

<http://www.kssos.org/Pubs/pubs_kar.aspx>

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# 7. Cost Proposals

1. Competitive Bidding-To solicit capitation bids from interested bidders, the State will utilize a competitive bidding process. Bidders are required to bid for all populations, services, and regions of the State. The State will provide Bidders with the items outlined below in the attached Bidder’s Library, and will require bidders to develop their rates assuming a normalized base risk adjustment factor of 1.0; assume that each Bidders’ enrolled risk is equal to that of the statewide population risk. Bidders will submit a single, statewide blended Bidder Initial Capitation Rate per member per month (PMPM) rate to reflect the proposed business model of that Bidder. The bids developed by Bidders should be developed by an actuary on an actuarially sound basis in conformance with 42 CFR § 438.4 and include a rate methodology letter signed by the actuary. The statewide blended rate is intended to cover all populations, services, and regions of the state per the specifications of the RFP. The rate bid by each Bidder will be used during the RFP process but will not necessarily be the final rate paid as the State may update the base data prior to the start of the program. The competitive bidding process will result in initial accepted rates for those Bidders where the State and the Bidder can agree upon a rate within the Initial Actuarially Sound Rate Range. If the base data is updated, a Final Actuarially Sound Rate Range will be set and the initial accepted rates will be updated to the same point in the Final Actuarially Sound Rate Range as the initial accepted rate was in the Initial Actuarially Sound Rate Range.
2. Competitive Bid Process- Bidders will submit cost proposals via theBidder’s Rate Development Template. The State will schedule individual meetings with each Bidder whose Technical Proposal has been accepted and require the Bidder to substantiate their Bidder Initial Capitation Rate development methodology, explain the Bidder’s prospective business model, and allow the State and its actuary to request clarification on any component of the rate development methodology and/or the Bidder’s prospective business model.

The State’s actuary will incorporate the substantiation provided by the Bidders in the bid submission and individual meetings on their rate development methodologies and prospective business models into a rate development methodology that will develop the State Initial Capitation Rate Range. The State Initial Capitation Rate Range will be a narrow range of actuarially sound rates, developed by varying components of the rate development methodology such as the assumed savings, calculated trend, and/or non-medical assumptions, applicable for all populations, services, and regions of the state.

1. Bidder’s Library, Financial/Rate Development Questions, and Bidder’s Conference(s) -To assist the bidders in developing a competitive bid rate, the State and the State’s actuary will provide information to prospective bidders in a Bidder’s Library:
2. Claims-Level Data (CLD) – detailed, de-identified database on the populations and services to be included within this procurement. To ensure the data remains de-identified, the claims-level utilization will use a scrambled member ID (consistent across claims to allow claims matching for individuals), will not include the Provider ID, and will not provide the member’s location (address, city, or zip).
3. Data Dictionary for De-identified detailed claims – to provide Bidders with a list of all fields provided in the detailed claims, including technical specifications, and descriptions of each field.
4. Summary Level Databook (SLD)– containing information on the populations and services to be included within this procurement on a statewide basis.
5. Category of Service Hierarchy Tables – to show the Bidders how the claims-level utilization data (#1 above) was aggregated into the summary level databook (#3 above).
6. KanCare Regional Factors – intended as informational only on the regional cost relativities.
7. KanCare Rate Cell Factors – intended as informational only on the rate cell relativities.
8. Current Kansas Medicaid Fee Schedule – to ensure that Bidders adhere to the RFP requirement that Provider reimbursement under KanCare be no lower than the current Kansas Medicaid Fee Schedule. Link to the Kansas Medicaid fee schedule (active via internet explorer): <https://www.kmap-state-ks.us/provider/pricing/refcode.asp>
9. Current KanCare Provider Frequency Databook – to provide Bidders data on the volume of services rendered by the current KanCare Providers.
10. Bidder’s Rate Development Template – to ensure that Bidders provide consistent levels of information related to the development of the statewide blended rate, and to assist the state in the bid scoring process.
11. Rate Cell Membership Mix– to ensure that Bidders are using consistent membership mix across rate cells to develop the statewide blended rate.
12. The Bidders will be allowed to submit questions regarding the financial terms of this RFP and the rate development process and the State will make those questions and the corresponding answers available to all Bidders registered for this RFP, consistent with Kansas procurement law. In addition, the State and the State’s actuary will conduct a Bidder’s Conference(s) to answer questions about the RFP, the financial terms, and the rate development process. Bidders are cautioned that any verbal answers provided during the Bidder’s Conference, per Kansas procurement law, are considered non-binding and only those answers formally provided in writing by the designated procurement officer are binding. Bidders are cautioned that any communication with any State or State’s actuary other than through the designated procurement officer is grounds for disqualification of their proposal.
13. Initial Actuarially Sound Capitation Rate Ranges -The State’s actuary will calculate a blended statewide Initial Actuarially Sound Capitation Rate Range to cover all populations, services and regions in accordance with generally accepted actuarial principles and in conformance with 42 CFR § 438.4 governing actuarially sound capitation rates for Medicaid managed care programs and the CMS Rate Development Guide. In consultation with the State’s actuary, the State will determine the Offer Point within the rate range that it will offer to Bidders after the Bid Submission. The State’s actuary will verify that the Offer Point is within the Initial Actuarially Sound Capitation Rate Range but will not disclose where within the rate range the Offer Point falls. The Offer Point may be specific to each Bidder and be based upon the relative position of their submitted statewide blended rate within the Initial Actuarially Sound Capitation Rate Range, or may represent a single point offered to all Bidders.  If the Bidder submits a statewide blended rate below the Initial Actuarially Sound Capitation Rate Range, the State will raise the blended rate to a point within the Initial Actuarially Sound Capitation Rate Range that, after accounting for all additional payment components (e.g., projected quality incentives earned), will be at the bottom of the Initial Actuarially Sound Capitation Rate Range. In no instance would the Offer Point be below the point to which bids below the bottom of the rate range would be raised to incentivize Bidders to bid appropriately. Based on CMS requirements, the State will raise a proposed statewide blended capitation rate that is below the Initial Actuarially Sound Capitation Rate Range despite the Bidder’s submission and attestation to ensure the Bidder does not violate the access and/or quality of care standards as described in the RFP.
14. Bidders that submit a statewide blended capitation rate above the Initial Actuarially Sound Capitation Rate Range may be given the opportunity to resubmit should the State decide to request Best and Final Offers (BFO). While the State reserves the right to request BFOs regarding the rate bid, the Bidder is cautioned to submit its best offer in its original bid as there is no guarantee the State will request BFOs.
15. Only Bidders that pass the technical phase of the RFP evaluation process will have their competitively bid capitation rates evaluated. The Initial Actuarially Sound Capitation Rate Range developed above will be based on data covering calendar years (CY) 2015 and 2016. To ensure the most recent data available is used to set the CY2019 KanCare capitation rates, the State’s actuary may update the base data to potentially include additional data, such as data from CY2017 and CY2018 to convert the Initial Statewide Blended capitation rate bids into Final Capitation Rates paid by region and rate cell. As part of the determination of the final capitation rates, each Bidder will have their actual risk adjustment factors (where applicable as all rate cells may not be risk adjusted) determined based on the final results of the auto-assignment and Member enrollment process.
16. The final capitation rate table will provide capitation rates by region and rate cell.
17. Cost Proposal Requirement: Each proposal must include a completed Exhibit 1-3, Rate Estimate Form in the Bidder’s Rate Development Template.
18. The Statewide Blended Rate for Contract Year 2019 shall be attached as Exhibit 1-3 to the Contract and shall be subject to adjustment by the State for Contract Year 2019 as set forth within Final Capitation Rates section below.
19. Final Capitation Rates
20. The State shall determine the final capitation rates paid such that the Bidder’s will maintain the same spot in the Final Actuarially Sound Rate Range as in the Initial Actuarially Sound Capitation Rate Range. After being positioned at the same point in each rate cell’s rate range, the State will apply, where applicable, the rate cell-specific risk adjustment factor.
21. Monthly Capitation Payments calculated in accordance with the Contract will be paid by the State. The State will reduce the capitation for Member Share of Cost Contributions. Capitation rates will be net of third party liability recoveries.
22. Pay for Performance
23. In Year 1 of the contract, the State will include a 3% quality improvement withhold that MCOs can earn back based on their performance on the quality improvement targets that will be included in the State Quality Strategy once it is revised for KanCare 2.0. The statewide blended Bidder Initial Capitation Rate per member per month (PMPM) rate submitted as part of the cost proposal should assume that 100% of the withhold will be earned back by the Bidder. The final Offer Point will incorporate projected quality incentives earned.
24. After Year 1 of the CONTRACT, the State also reserves the right to adapt the auto-assignment algorithm to incorporate differential enrollment percentage targets linked to an MCO’s quality improvement scores.
25. Prior to the CONTRACT implementation date of January 1, 2019, the State, through its Fiscal Agent, will notify Members of any changes to the MCOs contracting with the State to begin services January 1, 2019. Members who have chosen an MCO that was contracted previously with the State and will have a new contract will be auto-assigned to that MCO. Members who were enrolled with an MCO that is not continuing to contract with the State and newly eligible Beneficiaries will be assigned to a new MCO using an auto-assignment algorithm that ensures family members stay with the same MCO, that existing Provider-Member relationships are maintained to the extent possible, and that ultimately targets an equitable distribution of Members across the CONTRACTORS based on both numbers and acuity of Members and newly eligible Beneficiaries. All newly eligible Beneficiaries and existing Members will be mailed an enrollment packet that will include instructions about how they can keep their assigned MCO or select another MCO. As of January 1, 2019, Members will have ninety (90) calendar days to change MCOs without cause, as specified in 42 CFR § 438.56(c)(2). Absent for cause reasons for disenrollment as specified in the Contract, Members will remain enrolled in assigned MCO until the next annual open enrollment period that provides sixty (60) calendar days to select an MCO for the next Contract period.

1. Oracle is a registered trademark of Oracle and/or its affiliates. Other names may be trademarks of their respective owners. [↑](#footnote-ref-1)