C.25 Enrollees with Special Health Care Needs

REQUIREMENT: RFP Section 60.7.C.25

25. Enrollees with Special Health Care Needs (Section 35.0 Enrollees with Special Health Care Needs)
a. Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 "Enrollees with Special Health Care Needs" including. Include a summary of how the Contractor's experience in providing services to these populations has informed the approaches.
b. Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:
   i. Approach to identifying Enrollees.
   ii. Process for screening and assessing individual Enrollee needs.
   iii. Approach to providing education to Enrollees and caregivers.
   iv. Approach to providing transition support services.

> **Molina's outreach, innovative programs, and care management provide the services and supports necessary for Enrollees with Special Health Care Needs.**

Molina's 14 affiliate Medicaid health plans have developed a specialty in coordinating care for more than 1 million members of all ages with Special Health Care Needs. In addition to serving these individuals in Medicaid programs, we manage more than 60,000 Medicare-Medicaid Program (MMP) dual eligible Enrollees and more than 41,000 through Medicare Dual Eligible Special Needs Plans (D-SNP). Dual eligible Enrollees often have multiple complex conditions and other needs based on social determinants of health.

- Molina has extensive experience caring for ISHCN Enrollees, both in Medicaid and as the MCO with the largest Duals population
- Care plans and interactions focus on helping the Enrollee identify and reach personalized goals

Our experience with these populations has enabled us to develop a comprehensive care model based on innovations and evidence-based practices, and we will bring these innovations and practices to serve Kentucky's most vulnerable populations. Our individualized, person-centered care coordination approach places highly trained staff in close contact with the Enrollee, family and caregivers, and health and social services providers. Our model not only addresses the unique physical and behavioral health needs of Enrollees but also social determinants of health and community support services that best meet the Enrollee's needs. This approach promotes person-centered self-determination, in which an Enrollee's goals and preferences drive health outcomes, rather than healthcare dictating the Enrollee's life.

Across our enterprise, our enrollment includes more than 1 million people who fall under the special-needs categories defined by the Commonwealth. This includes nearly 5,000 individuals receiving foster care or adoption assistance; more than 400,000 who are aged, blind, or disabled (ABD); more than 191,000 who are over age 65; and more than 218,000 with chronic behavioral health illnesses. We also serve Enrollees who are homeless. In Kentucky we will assess for homelessness during Health Risk Assessments and other contacts, and the Enrollee file in our core processing system will flag this attribute unless or until we confirm that the Enrollee has secured housing.

Additionally, we will inquire during Health Risk Assessments and other point of contacts if an Enrollee has a legal guardian or an appointed representative. If so, we will flag information in the Enrollee file, so we can honor the guardian's role in healthcare decision-making throughout the levels of interactions Molina has with the Enrollee.

To identify individuals who require a higher level of care we will use initial assessments and predictive modeling, as well as regular re-assessments and referrals from Molina departments or external groups (state agencies, providers, community-based organizations, etc.). Recognizing the complexities within these populations, our care managers will collaborate with Enrollees and their caregivers, guardians,

medical homes/primary care providers (PCPs), specialty providers, non-medical providers, and community resources to ensure that the Enrollee's physical health, behavioral health, and functional needs and preferences are identified and addressed.

We always remember that each Enrollee is an individual with specific needs, goals, and desires. They are unique and their plan of care and treatment should always reflect that. As such, we will treat each Enrollee's case individually, creating a person-centered care plan with an emphasis on meeting the Enrollee's prioritized short-and long-term needs and goals. Care managers will reinforce the importance of the medical home—where one PCP or behavioral health specialist oversees all of the Enrollee's care—and will encourage Enrollees to use it for services. Our holistic approach to supporting these Enrollees will ensure access to treatment by a multi-disciplinary team of professionals to avoid fragmented care. It will encompass behavioral health, physical health, pharmaceutical, non-covered services, community supports, foster care/adoption assistance, caregivers, parents and/or custodial parents, adult guardianship, and school systems as needed. Where applicable, we will include social workers and other staff from the Department of Community Based Services or the Department of Juvenile Justice.

The Commonwealth's Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 35 Enrollees with Special Health Care Needs, recognizes eight classifications of Individuals with Special Health Care Needs (ISCHN). ISHCN Enrollees and individuals who have a legal guardian or appointed representative are flagged in Molina systems to facilitate identification and engagement that meets the Enrollees' needs. If the Department chooses to add a category of Enrollee to this list, we can quickly and easily accommodate this request.

Our proven approach to providing high-quality care and requisite supports for Enrollees with Special Health Care Needs is described below and meets all requirements in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 35, Enrollees with Special Health Care Needs.

a. INNOVATIVE APPROACHES AND EVIDENCE-BASED PRACTICES

Our experience serving ISHCN Enrollees has reinforced our understanding of their unique needs and provided the opportunity to implement solutions to meet those needs. Using population-specific advisory committees, we solicit input from Enrollees and their caregivers. We also use empirical data from assessments, health records, and utilization information to identify opportunities to improve care and outcomes.

Often, the most significant barriers for ISHCN Enrollees include housing, food security, health literacy, transportation, cultural competency, a support system, and social stigmas. Their need for support goes beyond healthcare and into everyday activities. Molina goes to great lengths to help Enrollees address these social determinants of health. As we further embed in the eight Kentucky Medicaid regions, we will target innovations uniquely suited to their needs and expand our relationships with community-based organizations that share our goals.

Our continuous research and refinement informs a model of care based on innovative approaches and evidence-based practices to serve all of the populations defined by the Commonwealth as ISHCN. These approaches and practices include:

Evidenced-Based Practices

- ✓ Caregiver Support
- ✓ Transition of Care (ToC)
- ✓ Motivational interviewing
- ✓ Trauma-informed care
- ✓ Trauma-focused Cognitive Behavior Therapy (TF-CBT)
- ✓ Trauma Symptom Checklist for Young Children
- ✓ High Fidelity Wraparound
- ✓ Peer Support Specialists

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Transition of Care. When Enrollees are hospitalized for a physical or behavioral health reason, our Transition of Care program begins planning for the post-discharge phase when they are still in the facility, and care managers continue to make regular contact with the Enrollee for 30 days post-discharge. Our program is a modified version of the Coleman model. That model defines
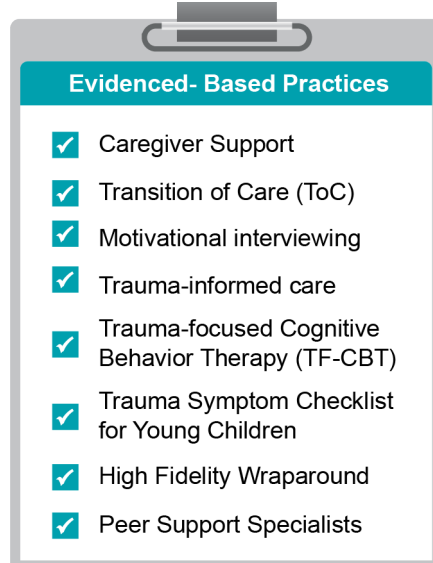
four pillars of care: medication self-management; use of a dynamic patient-centered health record to facilitate communication and ensure continuity of care; PCP/specialist follow-up after discharge; and knowledge of red flags. ***Based on our experience and outcomes, we have identified an additional three pillars: knowledge of advance care planning; identification of nutritional inadequacies; and functional deficits in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).*** The additional pillars are critical social determinants that lead to adverse health outcomes and increased risk for utilization. These three components present an opportunity to address Enrollee needs more fully, particularly when Enrollees are difficult to locate or homeless.

Caregiver Support. Enrollees need medical care, but they and their caregivers (usually family members) also need emotional and logistical support. Molina will use the American Medical Association's Caregiver Self-Assessment Questionnaire to assess the stress level of caregivers and will offer interventions when stress levels are high to promote the caregiver's well-being. Molina's enterprise-wide Caregiver Support Initiative, formalized in 2018, calls for embedding this questionnaire in the initial Enrollee assessment. As this initiative develops, we will link the questionnaire to HEDIS, care management and claims data, enabling us to obtain a clear picture of the link between the caregiver's emotional and functional well-being and the Enrollee's health outcomes.

We will offer Enrollees and their caregivers a toolkit to organize important information, have easy access to community resources, and assist with preparation for and follow-ups from provider visits. ***As a value-added service, Molina will provide for eight hours per year of respite care for each Enrollee's primary caregiver.*** The care manager will authorize this service upon request and will assist in scheduling an alternative caregiver (at Molina cost) or in sending the Enrollee to a facility or day program for a partial or full day. Or if preferred, this service can be provided in smaller amount of time over more days. The caregiver then will have free time for self-care and rejuvenation or to attend to personal matters.

Motivational Interviewing. All care managers receive training on this technique during their orientation. It emphasizes identifying and addressing ambivalence to strengthen the Enrollee's personal motivation, understand and meet the Enrollee where they are, and create a behavioral change while maintaining an atmosphere of acceptance, support, and compassion. We will listen to Enrollees and change our conversational approach with the understanding that Enrollees who identify their internal motivations for change and argue for its importance are more likely to be consistent and follow through with their identified personal goals.

Trauma-informed Care. This care recognizes and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Molina will provide ongoing training to our staff and provider network to foster a trauma-informed system of care.

Trauma Symptom Checklist for Young Children. The TSCYC is an easy-to-use instrument for assessing trauma-related symptoms in young children. The scales allow a detailed evaluation of post-traumatic stress symptoms and a tentative post-traumatic stress disorder (PTSD) diagnosis, and provide information on other symptoms such as anxiety, depression, and anger. As being removed from the family home is a trauma-inducing event, this tool will assist in identifying the impact of that trauma.

High Fidelity Wraparound. This team-based process uses an evidence-based, nationally recognized model to partner with Enrollees and families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy. The goals of the High Fidelity Wraparound process include:

- Creating a plan to meet the behavioral health needs prioritized by the youth and family
- Improving the youth and family's ability to manage their own services and supports
- Developing and strengthening the youth and family's natural social support system

- Integrating the work of all child-serving systems and natural supports into one organized and effective plan

Many of these practices apply to most or all of the populations classified as ISHCN. In addition, we have tailored services that primarily benefit one of the groups, although these innovations and evidence-based practices can apply to other groups as well.

Peer Support Specialists. Peer Support Specialists allow for non-stigmatizing peer support to help navigate systems and access community resources (e.g., housing, food, etc.) Because of a shared experience in SUD recovery, peer support specialists relate and develop trust with Enrollees and overcome communication barriers. Specialists are skilled in motivational interviewing and serve as role models and inspirations for long-term recovery.

Caring for Enrollees over Age 65

Nationwide, Molina has approximately 400,000 ABD Enrollees, 60,000 Enrollees enrolled in MMP plans, and 41,000 Enrollees enrolled D-SNP plans. For these individuals, physical and mental health declines represent an urgent need that requires our care managers to coordinate care as well as social supports and family/caregiver education.

Our parent company is an industry leader in developing care programs for this population. Our California affiliate health plan has developed *Dementia Capable Care, a set of best practices that incorporates assessment, integration of medical care, behavioral health care, social support, caregiver support, and staff training*. This effort began in 2014 in consultation with the community-based organization Alzheimer's Los Angeles. In June of this year, the health plan was invited to present this model of care during a CMS-supported conference call. The health plan continues to develop this model and will make it standard in all of our plans, including Kentucky.

Success Story in California

Our California plan received a referral for case management for an 82-year-old widowed woman who was experiencing memory loss. She had been diagnosed with diabetes, high cholesterol, high blood pressure, neuropathy, kidney disease, and incontinence. She lives with her son, and her daughter is the primary caregiver.

Molina's case manager worked with the county's social worker to address the family's needs. At one point, the member was leaving the house in the middle of the night to look for her children. The county increased the hours allotted for her care, adding protective supervision.

Our case manager determined that the member had not been evaluated for dementia and obtained a referral to a neurologist. The provider diagnosed dementia, began a new treatment regimen and educated the son and daughter about the disease and their mother's needs. The member continues to see her neurologist and take her medications.

We referred the member to Alzheimer's Los Angeles, where she received a Safe Return bracelet, additional education, and legal support around end-of-life planning. The daughter has participated in caregiver workshops. Our case manager and the county social worker continue to be in contact with each other and with the daughter, who is aware of options for further caregiver support and Community Based Adult Services if needed.

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Working with individuals 65 years or older, we have learned some unique challenges they face. Therefore, our care managers take into special consideration these life events that may affect the Enrollee:

- Decline in driving ability, which affects independence and often requires care manager's assistance in finding transportation
- Grief from the passing of friends, spouses, and partners and the loss of independence
- Co-occurring diagnoses such as depression or physical illness

- Transitions across multiple care settings such as home with caregiver support, paid support, long-term nursing home, and acute care rehabilitation facilities
- The need for end-of-life planning and the availability of resources (e.g., legal) and support

Care managers receive training in Tier 1 (all care managers assigned to the over-65 population) and Tier 2 (advanced training to become a dementia care specialist). Tier 1 covers the fundamentals of cognitive impairment, Alzheimer's Disease, and related dementias; practical dementia care management; cognitive screening tool administration; the impact of social determinants of health; and resources in the community. Tier 2 features deeper training on the same topics plus the IDEA! 3-part behavior management strategy and caregiver assessment.

Care managers' responsibilities encompass the entire continuum of care as described in Table C.25-1.

Table C.25-1. Care Manager Activities

Category	Activity
Care planning	- Work to improve Enrollee's quality of life by creating a care plan with person-centered goals, considering ways to protect an Enrollee's autonomy while ensuring safety - Also take into consideration the caregiver's goals for the Enrollee, which may be different from the Enrollee's, and work to mediate - Assess for and report abuse, neglect and financial exploitation - Keep emergency contact information current - Keep identified caregivers in the medical record - Create an emergency plan
Medical care and support	- Send PCP a letter when Enrollee screens positive for cognitive impairment - Involve PCP on multi-disciplinary team to ensure quality medical care to avoid inappropriate prescriptions - Improve PCP education on dementia care - Coordinate services across all the types of providers, care settings, and the community that the Enrollee interacts with - Refer Enrollee to waiver programs such as Long Term Services and Supports as appropriate and available
Home support	- Research and coordinate home modifications - Connect Enrollee to assistive technology - Decrease number of new environments for the Enrollee - Transition and diversion from long-term nursing placement as appropriate - Increase outpatient care in the Enrollee's home (PT/OT in the home if appropriate)
Community support	- Increase Enrollee's and caregiver's knowledge of community resources and connect Enrollee to dementia-friendly communities - Connect to resource hotlines and referral programs such as the Alzheimer's organizations and national hotline - Encourage Adult Day programs to keep Enrollees socializing and combat social isolation as available - Provide resources for legal services that could assist with obtaining Power of Attorney, legal guardianship, end of life planning, advance care planning such as NDRs (if desired), financial planning, etc.

Category	Activity
Caregiver support	• Assess and monitor caregiver's health and risk of burnout • Connect caregivers to support groups, counseling, education groups to increase their knowledge of diseases • Provide information on available programs and services • Decrease caregiver stress through respite, support groups (in person and online), encouraging caregivers to continue their own activities to keep their sense of self, and supplementing caregiving tasks as appropriate – **Molina value-added service: 8 hours of respite care per year for all caregivers of ISHCN Enrollees**

In addition to our regular channels of identifying Enrollees through assessments and referrals from providers or community-based organizations, our California affiliate health plan has created a pilot program with a medical supply provider that visits Enrollees in their homes. The provider added four additional questions to their existing intake progress. Molina selected these four questions for an indication the Enrollee could benefit from care management or community resources.

The medical supply provider reports these responses every week to our California affiliate health plan. Responses that indicate signs of dementia are referred internally for care management and externally to the Alzheimer's Association of Los Angeles for community resources.

Integrated Care for Homeless Individuals

Our Texas affiliate health plan developed a collaboration with several community organizations in Dallas to provide an integrated care solution for homeless Enrollees. We will explore similar collaborations and partnerships to address housing insecurity in Kentucky, both with CBO partners we have already secured and with any additional partners among the dozens of organizations we have had discussions with.

The Dallas initiative involves City Square (a community development non-profit organization offering a comprehensive array of social services), the Metro Dallas Homeless Alliance (which brings together more than 100 shelters, housing and supportive services programs in retooling homeless services into a crisis response system); and MetroCare (the local mental health authority) and Parkland Hospital. The collaboration:

- Focuses on working with City Square and Metro Dallas Homeless Alliance to connect Enrollees with potential housing and housing transition resources

- Provides in-person evaluation and connection to resources, education, and follow-up by Molina staff with homeless Enrollees

- Uses dedicated service coordination, mental health providers, and coordinated medical/psychiatric services to ensure Enrollees are accessing the right medical care at the right time, prevent inappropriate utilization, and stabilize Enrollees so their treatments can be shifted to less costly forums (e.g. from inpatient hospitalizations to outpatient treatments)

Housing Partnerships. We have made a national commitment to securing housing for our economically vulnerable, chronically sick, and homeless Enrollees. Our Texas and Ohio affiliate plans have partnered with CBOs to create an environment where Enrollees can remain independent while still receiving the attention they need and being monitored for changes in their health condition.

- In Texas, we have partnered with Prospera Housing Community Services to provide housing for Enrollees in San Antonio and Laredo and are working to expand the partnership to additional cities. The goal is to maintain Enrollees' independence and satisfaction. Prospera service care managers and onsite property managers connect residents with Molina care managers, assess social needs, and provide community improvement programs, such as health maintenance classes, a food bank, onsite GED classes, and after-school care. Prospera staff also alert Molina care managers to changes in Enrollees' health conditions.

- In Ohio, our affiliate health plan partnered with National Church Residences to create the Home for Life Program, which helps elderly Enrollees remain in their homes. The plan provides Enrollees in southwest Ohio with an in-home assessment and engagement program that addresses the social determinants that negatively affect their access to healthcare. The health plan then connects these seniors with traditional and non-traditional service solutions. A Molina care manager meets with each Enrollee in the home to provide support and complete assessments that identify the most vulnerable Enrollees, using a customized version of the evidence-based assessment tool, the National Church Residences' Care Guide, that evaluates an Enrollees' physical health, behavioral health, functional needs, and any social determinants that could put the Enrollee at increased risk. The care manager oversees the care plan and pays specific attention to helping Enrollees identify a PCP and ensuring that they make an annual visit at minimum. To achieve this, the health plan helps to coordinate Enrollees' transportation as needed.

Molina Housing Specialists. *We will dedicate four housing specialists to the Kentucky Medicaid program to help Enrollees resolve housing concerns.* Our Ohio affiliate plan began the Housing Assistance Program in May 2018. Housing specialists gather information regarding an Enrollee's current living situation, urgency of the housing need, safety concerns, income, and any barriers to housing. The housing specialist assists Enrollees with housing applications and other matters until housing is secured or rent and utility payment disputes are resolved. Our housing specialist in Kentucky will receive training on how to help Enrollees with BH concerns or other special needs access specialized housing assistance funds and recovery housing resources.

Homeless Respite. Our affiliate plan in Michigan has partnered with the Salvation Army to provide medical respite care for homeless individuals. A homeless Enrollee who is admitted to a hospital is, upon discharge, allowed to stay at the Salvation Army for 30 days. Molina provides nursing services and meals for the duration of the Enrollee's stay at the Salvation Army. Molina affiliate health plans enjoy strong working relationships with the Salvation Army throughout our enterprise. We will seek to collaborate with this exemplary organization in Kentucky to address Enrollees' housing and food insecurity needs.

Caring for Individuals with Chronic Physical Health, Behavioral Health Illnesses

In strategically selected hospitals (physical and behavioral health), we will embed care managers onsite. We base our decisions on geography and number of Molina Enrollees impacted at a facility. Embedding care managers allows for earlier identification of Enrollees, particularly Enrollees that use this service frequently. It also facilitates our Transition of Care process as the care manager can begin dialogue with the hospital's discharge planners and other personnel immediately.

In addition, the embedded care manager helps to build positive relationships with providers. We observe, exchange ideas, best practices, and can more quickly address any problems that arise. This innovation has been helpful in all of our plans in building an atmosphere of collaboration as described in Exhibit C.25-1.

Molina's culture of innovation shows in our collaborations toward a common goal. In Washington, our plan worked with one major provider to coordinate care for a high-needs Enrollee.

A 19-year-old Molina member had multiple physical health diagnoses:

Marfan Syndrome | Frequent strokes | Weight loss | Speech issues | Cardiac condition

He also suffered from depression and anxiety, was a high inpatient and ED utilizer, and frequently missed appointments and medications. Molina and Oregon Health and Science University partnered to care for the member. The multi-disciplinary team included more than a dozen staff from the two groups. In an unusual display of trust, the provider granted Molina system access to facilitate the member's care. Molina planned multi-disciplinary team meetings, accompanied the man to every appointment and built a relationship with the family, and participated in OHSU care conferences.

The improved communication among all parties helped the member maintain his appointment and medication schedule, gain weight, and decrease his trips to the ED.

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Exhibit C.25-1. Multi-Disciplinary Team for High-Needs Enrollee

Blind/Disabled Children Under Age 19

We plan to co-manage these individuals in collaboration with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Activities involved in this collaboration will include:

- Attendance at face-to-face assessments performed by DBHDID
- Integration of the DBHDID care/service plan into the care plan created by Molina's care manager and the Enrollee/guardian
- Regular and ongoing meetings with a DBHDID service coordinator to ensure all necessary services are available and provided
- Coordination of care management activities to ensure that they are completed in timely fashion and there is no duplication of effort
- Referral to DBHDID for reassessment and updated service plan after a change of condition

We have experience with a similar model through our affiliate plan in Texas, where acute care services for Enrollees in a 1915(c) waiver – which provides funding for home and community-based services for individuals who otherwise would meet requirements for institutional care – are carved out. Molina service coordinators collaborate with local agencies to ensure that acute care needs are delivered in a timely fashion.

Children Receiving EPSDT Special Services

We understand and acknowledge the Draft Contract, Appendix L, and the Commonwealth's list of special services covered by the Contractor. Among those services is home healthcare upon PCP referral and when prior authorization requirements are met.

Home care workers serve as "eyes and ears" for care managers, as they maintain frequent contact with Enrollees. As such, we have designed protocols whereby the home care workers ask a few probing questions to determine if an Enrollee needs assistance that requires the immediate attention of a care manager or healthcare professional. The questions are created by Molina based on our experiences in which inquiries have elicited responses that are most likely to lead to interventions that maintain or improve the Enrollee's well-being.

Children Receiving Services in a Pediatric Prescribed Extended Care Facility/Unit

A Molina care manager will attend rounds with facility staff and performs face-to-face visits and assessments to ensure quality of care. We will identify and promote community-based home-like settings in our network that allow children to receive care in a community setting rather than a facility.

Foster Care

Molina's integrated system of care recognizes the importance of providing person-centered services that are easily accessible to the Enrollee and portable based on life events. If awarded the SKY contract, the Molina Health Backpack will enable SKY Enrollees, caregivers, and system partners to access appropriate and timely information about the Enrollees they serve, through the Web or our mobile application. Available information will include:

- Results from the HRA, Enrollee Needs Assessments, and evidence-based tools such as the Trauma Symptom checklist

- Immunization records

- Current medications and prescribers

- Information regarding the Enrollee's overall health status: current conditions under treatment, height, weight, recent medical visits, allergies, lab results. It provides an easy to understand glimpse of the Enrollee's current health status while also providing the ability to drill down to past utilization data

- Providers that serve the Enrollee and their contact information: PCPs, specialists, dental providers, and BH Providers

- Medications: active prescriptions, drug utilization and prescribers

- Health alerts: upcoming and missed well-child screenings, upcoming medication refills and missed refills, and gaps in care

This information will help the DCBS Social Services Worker and caregivers understand the Enrollee's current health status, medications, and other important information. Identifying the Enrollee's PCP and specialist also allows the caregiver the ability to interact with both current and past caregivers to discuss issues of concern, medications, and current medical conditions. DCBS Social Services Workers and caregivers can download information from the Health Backpack and include it the Enrollee's Medical Passport. ***Enrollees will have access their Health Backpack for five years after disenrolling from the SKY program, facilitating transition to independence for transition-age youth and continuity in care for Enrollees who are adopted or return to their families.***

b. FACILITATING ACCESS TO SERVICES

Our care planning process is a person-centered and individualized process led and informed by the Enrollee's own voice, their strengths, preferences, natural supports, and desired services. It is collaborative, with procedures and protocols that include the Enrollee, caregiver, and others invited by the Enrollee (e.g., community partners, family, conservator, physicians, and other agencies).

The care manager will communicate with the Enrollee, caregiver, and choice of providers and individuals to outline the steps of the process; defining roles and responsibilities, milestones, timelines, priorities, and commitment of each of the parties. The care manager will share the goals of identified interventions and ensure alignment with the Enrollee's needs – that they are fully understood, achievable, measurable, and reflect the Enrollee's priorities and preferences.

For Enrollees who have a guardian, appointed representative or would like a friend or relative to help them with assessments or care planning, we will make accommodations to have their voice heard too. Some protocols to maintain Enrollee inclusion in assessment and care planning are:

- **Identification of the Person-Centered Team.** The Enrollee, their caregiver, and their choice of individuals make up the team.

- **Communication.** Involves identification of method and frequency of contacts and timely notification of information about service and care, which allows for informed decision making. The discussion takes place in the setting, language, and format identified by the Enrollee.

- **Conflict Resolution.** Involves developing strategies to resolve differences among multi-disciplinary team members, using the care plan and the Enrollee's stated preferences as a guide.

- **Molina Community Health Workers.** We help Enrollees navigate the complexities of the healthcare system by employing these community resources. Hired from within the communities they serve, these Molina Community Health Workers serve as "care manager extenders." They visit Enrollees in their homes or elsewhere in the community, observing their health and the impact of social determinants such as housing, food, and caregiver support. Molina's Community Health Workers are part of an Enrollee's multi-disciplinary care team. In all our health plans, we have found that they are particularly helpful in engaging Enrollees who have significant behavioral health issues and complex physical co-morbidities.

- **Care Connections.** *This team of nurse practitioners provide in-home visits to who have difficulty accessing care in facilities.* Among the services our Care Connections team provides are in-home visits for diabetic screening and care, and pop-up clinics. Our Care Connections will play a significant role in serving adults over age 65, homeless individuals (visiting shelters as needed), and individuals with chronic physical health illnesses and/or chronic behavioral health illnesses. *In California, the Care Connections team helped to increase the health plan's HEDIS rates across the board in diabetes-related measured and was instrumental in the plan's overall improvement by 16 percentage points in BP<140/90 in 2018.*

We will engage the Enrollee, their caregiver, and guardians in all aspects of care planning. When a person in the ISHCN group is identified, our care manager will contact the Enrollee, guardian if appropriate, and caregivers the Enrollee has identified to be involved and will explain the purpose of the call, describe how eligibility was determined, and affirm the Enrollee's right to decline outreach or to opt out of the program.

The care manager will complete an assessment and, working with the Enrollee, will develop a care plan that is meaningful and understandable by the Enrollee and caregiver, using the person's language as well as strategies specific to the person's condition. Services and benefits will be explained to the Enrollee or guardian to promote informed decision-making and to ensure that the Enrollee approves of the plan. The care manager will document the Enrollee's wishes on matters, including but not limited to, interventions, discussions with providers and team members, coordination of care, and cultural, linguistic and service preferences.

Through the assessment process, the care manager will discern the Enrollee's and/or guardian's main health concerns and will incorporate them in the care plan. The care manager will develop the care plan with the consent of the Enrollee or guardian with mutually agreed-upon goals, priorities, and outcomes. Each care plan update or change will be discussed and agreed to by the Enrollee or guardian. The Enrollee and the PCP will receive a copy of the care plan; for those Enrollees in adult guardianship, the appointed guardian will receive a copy as well.

Assessments and care coordination are conducted by highly qualified, professional care managers who are knowledgeable about Kentucky Medicaid covered services, our value-added services, community resources, Special Health Care Needs and federal and State requirements for the provision of services. Staff assigned to work with Enrollees in the ISHCN groups include experienced RNs, licensed vocational nurses (LVNs), licensed master social workers (LMSWs), and licensed bachelors social workers (LBSWs).

The care manager will monitor and review the PCP and specialist treatment plans to help remove barriers to care and to educate the Enrollee and/or caregiver and/or guardian on the plan. The care manager also will coordinate with community services that supplement covered services. All services, needs, and interventions from the plans will be documented in the Care Plan.

b.i. Identifying Enrollees

In addition to using eligibility and other state data files to identify Enrollees with Special Health Care needs, Molina will risk stratify all ISCHN populations before, or at the point of, enrollment, if historical data is provided. Our risk stratification aims to identify Enrollees with the highest priority and highest needs efficiently and effectively so our care managers can target, outreach, assess, and improve Enrollees' health outcomes sooner. We will stratify all Enrollees in three of our ISCHN populations to higher levels of care. These populations are:

- Children in foster care or receiving adoption assistance
- Children in a pediatric prescribed extended care facility or unit
- Children receiving EPSDT special services

Our other five ISCHN populations will be stratified in combination with any high-priority conditions (asthma, diabetes, cancer, COPD; and known health events, social determinants of health, pharmacy information, etc.), to identify and target Enrollees experiencing adverse health outcomes and can benefit from swift and immediate care management interventions. ISCHN populations with additional high-risk factors (Dx, Rx, recent health events, SDoH, etc.) being applied are:

- Enrollees over the age of 65
- Enrollees with a chronic physical health illness
- Enrollees with a behavioral health illness
- Homeless (upon identification)
- Blind/Disabled populations eligible for SSI

In addition to our risk stratification software output, results from our Health Risk Assessments (HRAs) will be used to further identify and stratify Enrollees into programmatic risk levels, informing the Enrollee's acuity level and frequency of intervention needed. Our HRA includes an assessment of chronic conditions, BH concerns, recent health events and SDoH. All of these factors, in addition to clinical judgment, will be used to identify ISCHN populations and define or refine the Enrollee's risk level. Care managers will review HRA results with the Enrollee and care team, as applicable, and will incorporate identified needs and interventions into the Enrollee's care plan.

We accept and evaluate referrals from all sources. These include but are not limited to:

Internal
- Nurse Advice Line
- Utilization Management
- Care management
- Behavioral health
- Medical Director

External
- PCP, Specialist
- Hospitals, Providers
- Schools, CBOs
- Enrollee, caregiver, or guardian

We also will deploy our sophisticated predictive analytics methodology to identify and risk stratify ISHCN Enrollees in need of timely care management intervention. Our software, systems, assessments, encounters and claims enable us to include all required risk factors, needs, conditions and populations, as applicable, per the Draft Contract to ensure our risk stratification methodology meets the needs of Enrollees.

Molina employs the *"No Wrong Door"* approach for referrals. In addition to the process stated above, we will receive referrals from Molina internal departments (including the Nurse Advice Line, utilization management, care management, behavioral health, and medical directors), and external entities such as state agencies, schools, community-based organizations, providers, PCP, specialist, and of course self-referrals from Enrollees, guardians or caregivers.

When Enrollees are identified as homeless through self-identification, HRAs or referrals, that information is attached to our Enrollee file in QNXT, our core processing system. It is then flagged for all departments

such as utilization management, care management, and the Call Center. The Enrollee's care plan will include stable housing as a goal (based on Enrollee preference) and will include interventions and milestones to achieve it. Homelessness will remain an identified attribute in the file until the Enrollee has secured stable housing.

Adult Guardianship Clients

Enrollees who are adult guardianship clients will be identified as ISHCN per the Contract, and the appointed guardian will be documented in the Enrollee's record. The Commonwealth's Department for Aging and Independent Living (DAIL) will complete the service plan. Molina will incorporate this service plan into the care plan we develop with the Enrollee/guardian. If the plan indicates the need for care management, Molina will work with DAIL staff and the Enrollee to determine the level of management.

Regardless of an Enrollee's participation care management, Molina will be responsible for the ongoing care coordination of adult guardianship clients to ensure access to needed social, community, medical, and behavioral health services. We will coordinate with other agencies that might provide waiver services for any LTSS needs and will ensure the Enrollee/guardian are aware of community-based resources to ensure that we meet all Enrollee needs and avoid duplication. Molina will submit a monthly report to the Commonwealth summarizing all adult guardianship cases.

We will work with DAIL to support Enrollee preference and will ensure that proper assistance is provided when needed (e.g., financial or healthcare decisions), so that the Enrollee remains at the center of their care.

b.ii. Screening and Assessing Enrollee Needs

Molina uses a standardized Health Risk Assessment (HRA) tool that allows for screening and a comprehensive assessment of an Enrollee's individualized health and psychosocial needs. The HRA includes but is not limited to the assessment of: physical and behavioral health conditions, substance use, medication use (including over-the-counter medications, herbal and vitamin supplements), functional and caregiver needs, cognitive concerns, psycho-social issues, cultural and linguistic needs, visual/hearing needs, and identification of the Enrollee's self-reported main health concern.

Exhibit C.25-2 shows the steps we will take to screen and assess to determine status as an ISHCN Enrollee.
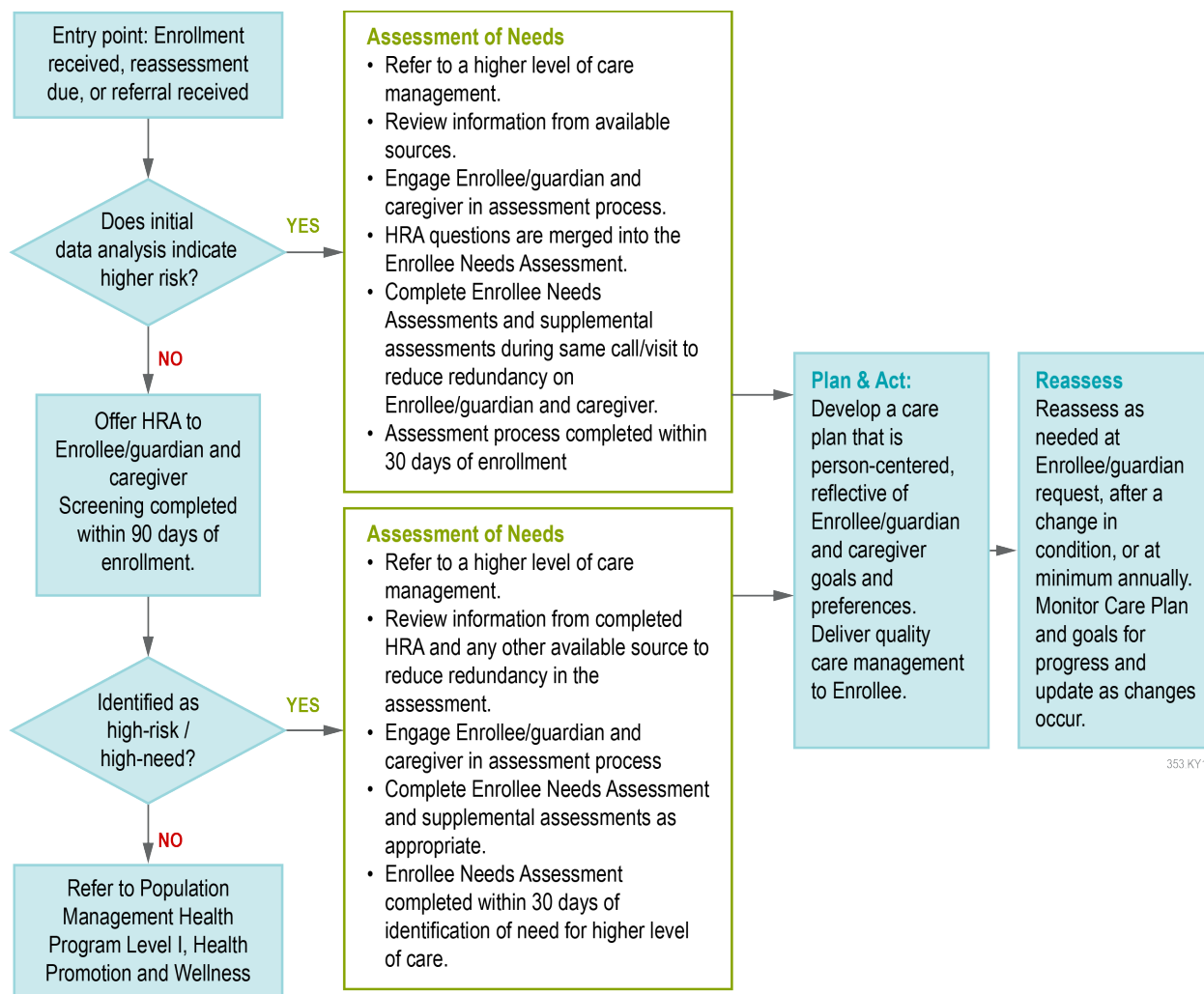
Flowchart:

Entry point: Enrollment received, reassessment due, or referral received

↓

Does initial data analysis indicate higher risk? — YES → (Assessment of Needs)

NO ↓

Offer HRA to Enrollee/guardian and caregiver Screening completed within 90 days of enrollment.

↓

Identified as high-risk / high-need? — YES → (Assessment of Needs)

NO ↓

Refer to Population Management Health Program Level I, Health Promotion and Wellness

Assessment of Needs (top box)
- Refer to a higher level of care management.
- Review information from available sources.
- Engage Enrollee/guardian and caregiver in assessment process.
- HRA questions are merged into the Enrollee Needs Assessment.
- Complete Enrollee Needs Assessments and supplemental assessments during same call/visit to reduce redundancy on Enrollee/guardian and caregiver.
- Assessment process completed within 30 days of enrollment

Assessment of Needs (bottom box)
- Refer to a higher level of care management.
- Review information from completed HRA and any other available source to reduce redundancy in the assessment.
- Engage Enrollee/guardian and caregiver in assessment process
- Complete Enrollee Needs Assessment and supplemental assessments as appropriate.
- Enrollee Needs Assessment completed within 30 days of identification of need for higher level of care.

Plan & Act: Develop a care plan that is person-centered, reflective of Enrollee/guardian and caregiver goals and preferences. Deliver quality care management to Enrollee.

Reassess: Reassess as needed at Enrollee/guardian request, after a change in condition, or at minimum annually. Monitor Care Plan and goals for progress and update as changes occur.

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Exhibit C.25-2. Screening and Assessment for ISHCN Enrollees

To reduce redundancy and assessment fatigue, our care managers will complete a thorough review of the any health records, historical claims data, utilization information, and prior contacts with Molina for accurate diagnosis or description of disability. *We will use Member360, a care management application that combines data from our core systems and external sources to provide a 360-degree view of the Enrollee and guide the care planning process.* This step is completed before assessments, care planning, and outreach to Enrollees, caregivers, or guardians. The care manager becomes the single point of contact for the Enrollee and caregiver.

After initial assessment, the care manager will work with the Enrollee/caregiver/guardian, PCP/specialists, other agencies, and the multi-disciplinary care team to develop the care plan. Our care managers will reassess the Enrollee's needs regularly based on the Enrollee's person-centered care plan, evidenced-based clinical guidelines, upon Enrollee request, and during any significant change in health status. Significant changes in health status can include events such as ED visits, an inpatient admission, loss of a caregiver, or a change in social/environmental need such as housing or transportation. After any contact or assessment that identifies a change, the care plan is updated to reflect modifications and progress toward goals. The updated care plan will be shared with the Enrollee and members of the Enrollee's selected care team.

We also will assess on an ongoing bases the Enrollee's and/or caregiver's knowledge of disease processes; barriers to healthcare (e.g. transportation, finances, housing, food security, support); self-management skills; access to providers; home safety; community engagement including employment and care across the continuum of service needs. The care manager will monitor and review PCP and specialist treatment plans, when available, to assist in removing any potential gaps in healthcare and assist the Enrollee and/or caregiver in better understanding the treatment plan. The care manager will assess the ongoing needs of the Enrollee and will re-stratify as deemed appropriate in consultation with the Enrollee and/or caregiver.

Table C.25-2 describes assessment tools for specific populations within the ISHCN category:

Table C.25-2. Assessments

ISHCN	Examples of Supplemental Screening and Assessment Tools
Assessment for adults over age 65	The **AD8** dementia screening is an eight-item test to help discern whether an Enrollee shows is simply aging or is showing signs of dementia. A positive screening leads to further assessment, laboratory testing, and a physical exam and neurological consultation.
Assessment for Enrollees with chronic PH illnesses	We use **condition-specific assessments, guideposts, and action plans** for such conditions as asthma, chronic obstructive pulmonary disease, coronary artery disease, hypertension, diabetes, and HIV. Care managers will educate Enrollees on triggers and symptoms, and how to recognize a crisis, to attend PCP and specialist appointments, and to take medications as prescribed.
Assessments for Enrollees with chronic BH illnesses	These include the **PHQ-2 and PHQ-9 depression screening**, the **Depression Initial Assessment** (following the PHQ-9), **Behavioral Health Assessment** (Adult), **Edinburgh Postnatal Depression Scale, CAGE Aid** for substance abuse, **NIDA Quick Screen**, **ASAM Substance Use Assessment**, and a **Behavior Support Plan** to outline actions for behaviors that threaten the health and safety of an Enrollee and/or others near them.
Assessments for children receiving EPSDT Special Services	These include condition-specific assessments, such as the **Pediatric Symptoms Checklist (PSC-17)**, which screens for emotional and behavioral problems and is typically used for depression (internalizing) in children; and the **Behavioral Assessment, Adolescent and Child,** for Enrollees age 6-17 years whose main health concern is one more behavioral health conditions other than depression or substance abuse.
Assessments for children receiving services in a Pediatric Prescribed Extended Care facility or unit	The **Nursing Facility Transition Preference Assessment** helps to determine the Enrollee's or guardian's interest and ability in transitioning out. The **Nursing Facility Transition to Home Assessment** will be used to determine the Enrollee's needs when transitioning home from a facility.
Foster care or adoption assistance	If awarded a SKY program contract, we will leverage the **Child Trauma Screen Generic** screening tool for children is a validated tool to be completed with children age 7 and over and/or caregivers of children age 6 and older. However, like many of our other validated tools we will use this with all individuals in the SKY program regardless of age.
Blind / Disabled Children under 19 and Related Populations eligible for SSI	**Quality of living age-based assessments** assess Enrollees and caregivers for the purpose of improving functional capacity and regaining optimum health and quality of life by educating, assisting, and facilitating access to the most appropriate healthcare services available.
Homeless	Molina has developed a **Housing Specialist Referral Form** for care managers to further identify primary barriers preventing an Enrollee from obtaining secure housing. This tool is the starting point to connect the Enrollee to Molina's housing specialist.

ISHCN	Examples of Supplemental Screening and Assessment Tools
Multiple populations	The American Medical Association's **Caregiver Self-Assessment Questionnaire** assesses the stress level of caregivers and offers interventions when stress levels are high to promote the caregiver's well-being. Molina's enterprise-wide Caregiver Support Initiative, formalized in 2018, calls for embedding this questionnaire in the initial Enrollee assessment. **Universal screening for depression and Substance Use Disorder (SUD).** Our standard HRA includes the assessment of substance use and medication use (including over-the-counter medications, herbal and vitamin supplements). Enrollees identified as having mental health and/or SUD issues will be managed by one of our BH care managers (licensed BH clinicians, or RN), who conducts further specialized screenings to determine service needs.

b.iii. Providing Education to Enrollees and Caregivers

When an Enrollee is classified as ISHCN, the care manager will contact the Enrollee and caregiver (if applicable) to explain the purpose of the higher level of care, including the basis for the Enrollee's eligibility. We will distribute information and materials specific to the Enrollee's needs, goals, and preferences. We will offer health educational material regarding the Enrollee's condition(s).

The care manager will continue to educate the Enrollee and caregiver as long as the Enrollee is receiving services as a participant in the ISHCN program. The care manager will address the steps to success; explain roles and responsibilities, milestones, timelines, and commitment by all parties; and outline the goals, interventions, priorities, preferences, and outcomes aligned with the Enrollee's needs. Care managers, with input from the multi-disciplinary team, will communicate with Enrollees about all available options.

For all needs, including PCP selection and to meet with a care manager, *Enrollees have the option of visiting one of our six Molina One-Stop Help Centers throughout the Commonwealth.* These centers will serve as information and education resources for all Enrollees and include printed materials about our programs and services, as well as amenities such as free computer and WiFi access.

We also will communicate with Enrollees through:

- **Written Materials.** The Welcome Kit, Enrollee Handbook, and guides to our Population Health Management programs will be available in the Enrollee's preferred language (English, Spanish, or prevalent language) as well as in alternative formats such as Braille, audio, or large print upon request. We can also provide audio disks to accommodate Enrollees with vision impairments.

- **Age-appropriate and Condition-specific Materials** for Enrollees. Exhibit C.25-3 shows a book cover from our "Clear and Easy" series of age-appropriate, educational materials about managing chronic conditions.

- **TTY/TDD and Relay Services** for Enrollees who are deaf or hard of hearing. These services will be used as part of our assessment and care planning process.

- **Online and Printed Provider Directories,** including specialty type (such as geriatrics) and physical accessibility symbols, will help Enrollees select a provider that meets any of their needs. When accessing Molina's online directory, Enrollees will be able to search for providers with wheelchair-accessible offices.
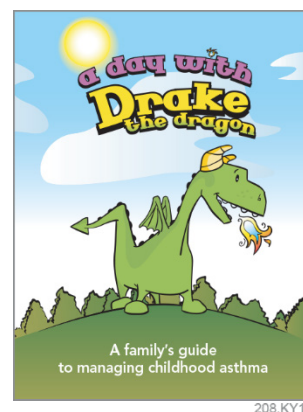

Exhibit C.25-3. Clear and Easy Booklet

- **Molina Mobile App.** The app will allow Enrollees to view their current benefits, upcoming appointments, medications, allergy list, and conditions. In addition, Enrollees will receive alerts about needed screenings, treatments, and immunizations. Enrollees can view their care plan and information about their multi-disciplinary care team, and they can use the app to text-message a care manager.

- **Enrollee Web Portal.** We maintain a secure, HIPAA-compliant Web portal for Enrollees. We will include the Provider Directory and a community resource guide to assist them in locating organizations that address one or more social determinants of health. Enrollees can view and print their care plan and communicate with a care manager, and they can read more information on programs such as EPSDT and dental services. Exhibit C.25-4 shoes the Web portal for Enrollees.

- **Provider Web Portal.** We will notify an Enrollee's PCP immediately through the portal when the Enrollee fails to receive a timely screening or service. Monthly, we will supply providers with a HEDIS Gaps in Care report for all Enrollees, viewable on the Provider Scorecard. We continually review claims data to identify Enrollees who have missed important preventive screenings or other services such as dental or maternity care. We will report if Enrollees have utilized the ED inappropriately. Our Quality Improvement (QI) department also will assist providers by contacting Enrollees who have missed services and by helping Enrollees schedule appointments with the provider.

Exhibit C.25-4. Enrollee Web portal Home Page

Our care managers will assess for knowledge deficits in Enrollees' and families' abilities to manage their healthcare condition and educate Enrollees regarding signs and symptoms to support self-management and autonomy. Care managers will educate the Enrollee about community resources and housing options as needed. Care managers will teach and encourage Enrollees to use their medical home (e.g. PCP, BH clinician, or other specialist) when they experience signs and symptoms that warrant provider intervention.

We will make a special effort in this population to communicate with caregivers. In a Caregiver Support Initiative that began in one affiliate plan in 2015 and has since expanded enterprise-wide, we identify caregivers during Enrollee contacts – and urge providers and hospitals to do so as well during all interactions – and increase the level of support they receive. Our Caregiver Toolkit includes information

and tools to help Enrollees. It also will include a section solely devoted to caregiver self-care, with a notification of *Molina's respite care (8 hours per year for each Enrollee)* and a listing of additional respite resources, support groups, and adult day care. In addition, we will refer caregivers to evidence-based programs that reduce the risk of falls, a possibility that can cause great stress in caregivers.
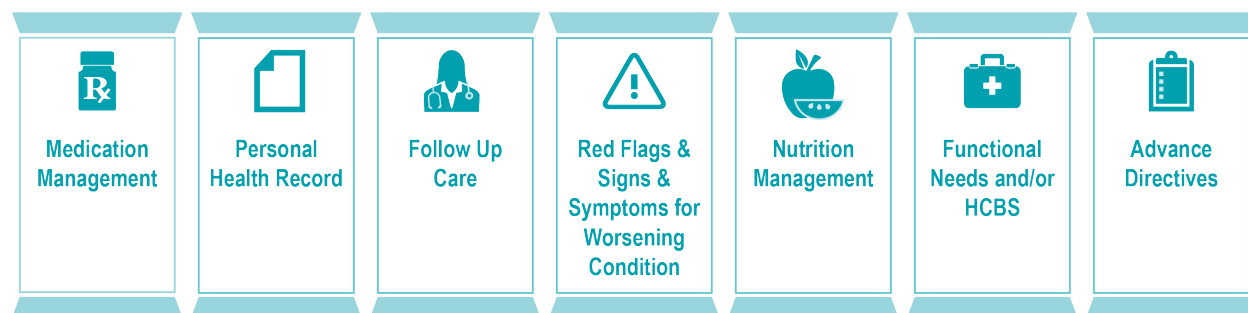
b.iv. Providing Transition Support Services

Molina defines transitions as moving from one care setting to another. Transitions include but is not limited to admission or discharge from to a hospital (physical or behavioral health), emergency department, other acute care setting, nursing facility, institutional setting, or a community based home environment. Transitions can have both positive and negative impacts on Enrollees and their caregivers, including changes related to:

- Coping methods
- Physical and mental resources
- Mood and emotions: depression, grief, helplessness, fear, anger, euphoria, relief
- Social integration
- Self-management
- Substance use

For Enrollees with special healthcare needs experiencing a transition of care, they will benefit from our evidence-based and industry-leading *Transition of Care program*. Proactive planning for the post-discharge phase will begin while the Enrollee is still in the facility. The purpose of the Transition of Care program is to monitor and promote the coordination of physical and behavioral healthcare and support services across healthcare settings, to ensure continuity of care after the Enrollee moves from one setting to another, and ultimately avoid preventable readmissions. Our Transition of Care program is based on the Coleman model, which provides Enrollees with tools and support

> **Readmissions in Texas where approximately 50% of members qualify as ISHCN decreased from 11% to 7% in one year following implementation of the Transition of Care program.**

that promote knowledge and self-management, including addressing the social determinants that often lead to re-hospitalization and institutionalization. Molina implemented an expansion of the Coleman model by providing transition of care support through seven "pillars", including three pillars addressing individualized needs and social determinants. These are represented in Exhibit C.25-5 below.

| Medication Management | Personal Health Record | Follow Up Care | Red Flags & Signs & Symptoms for Worsening Condition | Nutrition Management | Functional Needs and/or HCBS | Advance Directives |

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Exhibit C.25-5. Molina's Transition of Care Pillars built upon the Coleman Model

Through Molina's Transition of Care program, Enrollees will be assigned Transition of Care coaches who facilitate targeted interventions, including educating and empowering Enrollees and promoting self-management of their health. Transition of Care coaches will ensure that all Enrollees receive outpatient follow-up and continuing treatment before discharge. This will include assisting Enrollees with scheduling outpatient treatment within seven days from their identified date of discharge and confirming with the Enrollee that he or she has arranged for transportation. We will work with family, friends, and

community resources to ensure the Enrollee has appropriate home supports such as nutritional meals, accessible housing, and plans to engage in social support programs based on their needs and preferences. Molina will promote continuity of care for Enrollees with Special Health Care needs and their caregivers by bringing together the right team members and system partners at the right time to connect Enrollees to the right services and supports. Below, we describe how we tailor our Transition of Care program to meet the specific needs of each special healthcare needs population.

For Enrollees with Special Health Care needs, Molina's additional three pillars address key elements for successful transitions and sustained results including:

- Post-transition long-term support through care management and care coordination
- Proactive transition planning with long-term care manager and Enrollee's chosen care team
- Interdisciplinary care team meetings with clinical experts
- Coordination with community-based resources based on person-centered needs and care plans

For Enrollees with Behavioral Health Illness, Serious Mental Illness (SMI) or at Risk of Institutionalization, Molina will oversee transition planning and continued care coordination activities when they are transitioning from licensed personal care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing. To support a successful transition, we will perform a comprehensive physical and behavioral health assessment in advance of transition to the new setting and ensure frequent and consistent contacts post transition. Assessment protocols include reviewing the Enrollee's person-centered recovery plan and the level of care determination from the provider agency and applying our standard Utilization Management (UM) procedures. We will provide all medically necessary services that are recommended in the recovery plan.

A care manager specializing in behavioral health will serve as the point of contact for the Enrollee, PCP, and specialist. Communications to Enrollees will be customized based on their person-centered care plan and may include hospital calls or in-person visits, transition follow-up visits or phone calls to Enrollees, follow-up letters, and the delivery of educational materials. Communication will be frequent over a 30-day period beginning when the Enrollee is in the hospital/facility. We will make a phone call or home visit within 48 hours of discharge, and again at seven and 14 days from the previous contact, to review the Enrollee's condition and ensure safety and well-being. Our care manager will schedule all follow-up appointments and will ensure that prescriptions are filled and durable medical equipment is delivered. During contacts, we will assess the Enrollee's living situation and other social determinants of health. We will ensure that there is a caregiver involved, and the caregiver is aware of any additional short-term and long-term needs.

The Enrollee will continue to receive care management services while enrolled in the Transition of Care program. The care manager will reassess the Enrollee, update the care plan, and adjust the Enrollee's level of care management, as needed. We continually will assess for risks and factors that may lead to hospitalizations or institutionalizations, and we will put person-centered interventions in place as part of the care plan to help the Enrollee remain in the community as long as possible.

For Youths Aging Out of Foster Care, we will provide transition to adulthood supports for all youth in our system of care. We will work closely with DCBS to conduct early family reunification assessments to identify Enrollees who are: (a) likely to reunify; or (b) likely to age out of the Foster Care system without reunifying with their birth family. Molina further will use our family reunification assessment tool to ensure needs are met (described at end of section).

As Blind/Disabled Children under age 19 and Related Populations Eligible for SSI often have unique physical, emotional, and nutritional needs when transitioning amongst settings and those needs may extend beyond the Transition of Care protocols, which is why the Molina care manager will play an active role in the transition process. For children with disabilities, Molina will collaborate with DBHDID to determine where home and community-based services could be made available for Enrollees as part of

their Transition of Care. The Molina care manager works with the DBHIDID service coordinator to ensure care management activities and both acute care and social needs are met during transition.

For adult Enrollees that are blind or disabled, the Transition of Care coach will proactively work with the care manager to ensure affordable, accessible housing is maintained during their acute/institutional stay or secured and prepared in advance of their discharge, coordinate changes related to DME, and coordinate with community resources for the provision such as social supports and assistive technology. The care manager will actively engage with the Enrollee and their care team throughout the transition, updating care plan goals and progress.

Adults over the Age of 65 can receive care in multiple settings and experience transitions frequently. In fact, these transitions to different care settings are not necessarily linear and often have a domino effect for the Enrollee. Improving the transition will not only improve outcomes but also helps the Enrollee from readmitting to another setting for care. For adults over the age of 65, Molina will work very closely with Primary Care and specialist doctors to ensure hospital admission notifications, discharge plans, medication changes, care plans, and Enrollee's ability to self-manage care, are shared to ensure any pending lab work and tests are completed once the Enrollee leaves the hospital. Additionally, our Transition of Care coaches will be diligent to identify potential fall risk, incontinence, food insecurity, medication management and monitoring, cognitive changes, social isolation, and natural supports, such as help from family and friends to complete ADLs/IADLs. For those with such risks or support needs, Molina may:

- Deploy a care manager to perform an evidence-based in-home assessment and work with the Enrollee to establish or update care goals with interventions to prevent readmission or institutionalization
- Engage Molina Care Connections to perform home visits
- Offer Medication Therapy Management program
- Offer our value-added Respite benefit
- Assess caregiver stress level and offer interventions to promote longevity of natural supports

For Enrollees that are transitioning from a post-acute facility, we will administer the Nursing Facility Transition Preference Assessment and the Nursing Facility Discharge Checklist to ensure Enrollees are prepared and in-home transition follow up is completed.

Enrollees that Struggle with Homelessness are not in one particular age group and do not have defined set diagnosis or income level. Homelessness can affect anyone, any age, any race, or gender. Enrollees that are chronically homeless or at risk of homelessness can be hard to locate, making transitions difficult. To overcome this barrier, Molina will use Molina Community Health Workers to locate Enrollees that are chronically homeless and establish trusting relationships. Through these relationships, the Molina Community Health Worker will support Transition of Care coaches and care managers to engage the Enrollee experiencing transitions and our internal housing specialist to help find stable housing.

Molina also will partner with community agencies that aid with electric or water bills and even rent for those that are at risk of being homeless. By working with community agencies, Molina is finding creative solutions to reduce risk of homelessness.

> **Understanding the Needs of Homeless Individuals Upon Hospital Discharge**
>
> We understand the tremendous challenges homeless individuals face, including having somewhere to go when they are discharged from hospitals. Our Florida affiliate is "renting" beds from a local shelter for their members to go to upon hospital discharge. Through this innovative program, the health plan also helps individuals find suitable, more permanent housing and connects them to community resources and support.

Success Story in Florida

During a face-to-face visit with a Florida member in her home, she disclosed to the Molina case Manager that the electrical wiring in her home in need of repair and this was causing significant stress for her. She was worried that her home was becoming an unsafe fire hazard, but she had nowhere else to go. Molina's case manager completed an assessment of the home environment and discussed other housing options. During the assessment, the case manager received a mild shock when trying to turn on the light.

Our case manager and the member came up with a safety plan and considered other housing placements and resources. The member expressed that it was her preference and desire to remain in this home for as long as possible. Therefore, our case manager knew that the electric work needed to be resolved.

The member requested that their electrical outlets and switches in her home be repaired under her Medicaid benefits. Molina was unable the cover the electrical repairs under Medicaid benefits with the reasoning explain to this member. However, Molina did not stop there.

We referred this member to the County Assistance Program for Seniors. This program was able to complete the needed electrical repairs and the home no longer poses a risk for this member. She was very grateful that her Molina case manager took the time to listen, understand her problem, and not say "no". Molina helped her get what she needed to stay in her home. **By connecting this member to the correct resources, we were able to prevent her from become homeless by ensuring her home environment was safe.**

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Furthermore, if an Enrollee is living in a shelter, we will go to the homeless shelter to engage that Enrollee, to educate on benefits, and to see if they would like to have assistance with finding a place to live. During this work, the Molina Community Health Worker will follow the Enrollee through all of their housing transitions by engaging with the Enrollee at the homeless shelter, to temporary housing, such as transition program, to long term housing. These activities will be done both in rural and urban settings, tailored to the needs and circumstances of the Enrollee.

To engage Individuals with Chronic Physical Health Illnesses, Molina will proactively identify and outreach to offer care management as these Enrollees are often at high risk for avoidable transitions between home, hospitals, or post-acute facilities. Through person-centered care management, we will help the Enrollee identify health and social risk factors that impact how they want to live. Using evidence-based assessment protocols, we will help the Enrollee set goals and design interventions to enable them to live in the least restrictive setting of their choice. When transitions occur, our Transition of Care Coaches will take a holistic approach toward planning, to address not just the episode that precipitated the transition but, co-morbidities that may be triggered by the event. This may include, with Enrollee consent, engaging family and friends early in the process for support in the transition process or enrolling in care management, Medication Therapy Management, and community-based programs such as nutrition, exercise, intensive population health, or fall prevention classes.

For Children receiving EPSDT Special Services, one of the most important transitions they will have is when they age out of this benefit. To ensure no gaps or issues with access to care occurs, Molina has established an age-out process that keeps the family informed of assessment schedule and when/how/why services will be reduced and gradually reduce services, so the Enrollee and family are prepared for adult services at a different scope, duration, and frequency than child services. This includes notification in writing to Enrollee/family member to explain to how to obtain services and care once the Enrollee has aged out. Molina will also follow up after the child aged out to ensure the transition went smoothly. We will have a single point of contact for the family and or Enrollee to contact during this period of transition.

For Children receiving Services in a Pediatric Prescribed Extended Care Facility or Unit, Molina care managers attend rounds with facility staff, perform face-to-face visits and assessments, ensure quality of care, participate in developing and reviewing individual health plans, partake in caregiver trainings and or liaisons training, and engage in the approval process for "Do No Resuscitate" requests

when parental rights have been terminated. Molina offers community-based home-like settings for children as a place they can transition to, live, and receive the care they need in the community rather than in a facility setting.

If and when the child is ready to transition from the PPEC unit, the transition will take into consideration all of the services and resources the child and family will have at home. A few examples of these needs could be ventilator care, tracheostomy care, oxygen, skilled nursing, emotional care, psychosocial care, home modifications or environmental issues or concerns, and caregiver support. Molina not only will arrange medically necessary services but will also work with the child and the caregiver to help obtain needed services from other means, including, but not limited to, community resources, school-based programs, family members, community programs, or caregiver support programs.

If awarded a SKY contract, Molina will provide the Commonwealth with our family reunification assessment tool, which we developed based on best practices our partnership with stakeholders in affiliate plans. We will partner with DCBS to adopt its tool and/or adapt our tool to the specific needs in Kentucky. In our experience, completing a family reunification assessment enables us to provide the right supports and services to meet each SKY Enrollee's specific, individualized needs.

Molina's assigned care coordination team will conduct a comprehensive assessment before a foster child's 16th birthday or as part of the Health Risk Assessment for Enrollees 16 or older at the time of enrollment. We will reassess Enrollees' transition to adulthood needs annually. We will include additional assessment tools and input from additional system partners, as appropriate, such as special education and/or juvenile justice. For Enrollees with juvenile justice involvement, we will coordinate with the DJJ Roundtable before initiating any assessments.

Using the assessment results, the care coordination team will assist transition-age youth in self-directing a Transition to Adulthood Service Plan that will facilitate their independence in adulthood. The Service Plan will address the following areas:

- Access to physical and behavioral health services
- Independent living skills
- Employment/vocational/education interests and supports
- Transportation needs
- Housing
- Food security
- Financial resources
- Continuity of care during the transition

Molina's care managers will closely monitor Enrollees' transitions from the children's system of care or juvenile justice placement. We will follow Enrollees until they have fully and successfully connected to their providers in the community and adult system of care.

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