

G.11 Utilization Management

REQUIREMENT: RFP Section 60.7.G.11

11. Utilization Management

- a. Describe how the Vendor will collaborate with Network Providers, the Department, DCBS, and DJJ to provide coordinated care for those Kentucky SKY Enrollees accessing psychotropic medications.
- b. Describe how the Vendor will collaborate with the Department, DCBS, DJJ, hospitals, psychiatric residential treatment facilities (PRTFs), residential Providers, physical and Behavioral Health Providers and others on Discharge Planning needs of Kentucky SKY Enrollees across all levels of care.

Molina's Enrollee-focused approach to Utilization Management will support Enrollees through transitions of care, reduce the need for institutional care, reduce use of psychotropic medications, and lead to better health outcomes.

Molina has 25 years of experience developing Utilization Management (UM) protocols, policies, and procedures, including specific protocols for prior authorization of psychotropic medications in a Medicaid managed care environment. Our program uses a System of Care approach, where experience shows that a high touch, person-centric care environment for at-risk Enrollees supports better health outcomes. Our UM program will provide our SKY Enrollees with the appropriate services they need to maintain good health without unnecessarily overusing resources. We will integrate physical health, behavioral health, and social support services to meet the individualized needs of our SKY Enrollees and their caregivers and to optimally respond to changes in the child or youth's condition. Our Enrollee-focused environment, described in this response, will support better health outcomes, reduce the need for institutional care, reduce use of psychotropic medications, and help Enrollees through transitions of care.

a. PROVIDING COORDINATED CARE FOR ENROLLEES ACCESSING PSYCHOTROPIC MEDICATIONS

The use of psychotropic medications in children and youth involved in the Foster Care system is an issue of growing concern among clinicians, child serving agencies, and legislators. Almost half—42%—of the children in Kentucky's foster care system have been prescribed at least one psychotropic medication, almost double the national average. Antipsychotics, antidepressants, drugs for attention deficit disorder and attention deficit/hyperactivity disorder, anti-anxiety medications, and mood stabilizers are some of the more commonly used psychotropic drugs. While they produce good results among most children and adolescents, they also can cause worrisome side effects in others, and their interactions with each other can create problems as well. Through a collaborative process for utilization management and psychotropic medication review, Molina will work to monitor and reduce the use of these medications among SKY Enrollees. Our approach includes the following components:

- Developing a shared clinical practice model based on a developmentally-informed biopsychosocial approach, trauma-informed care principles, and system of care principles
- Creating processes for sharing clinical and medication information for SKY Enrollees served by multiple systems
- Implementing a clinical rounds process for SKY Enrollees with complex needs

SHARED CLINICAL PRACTICE MODEL

Molina's medical director will convene a Clinical Practice Workgroup that consists of medical directors and clinician representatives from the Department, DCBS, and DJJ to develop a shared clinical practice model for prescribing psychotropic medications for SKY Enrollees. This workgroup will share their current practices, discuss the factors that contribute to the high rate of psychotropic medication prescribing patterns and agree upon clinical practice model that will be adopted by all participating

organizations. The Clinical Practice Workgroup will leverage their collective expertise to put into writing standards and guidelines that include:

- A comprehensive behavioral health assessment before prescribing psychotropic medications
- Expectations for Enrollees to receive a combination of evidence-based psychosocial interventions and psychotropic medication when indicated
- Appropriate prescribing guidelines based on Enrollee age: 0 to 5, 6-12, 13-17 and over 18
- A consistent definition for inter- and intra-class polypharmacy and associated standards
- Standard guidelines for prior authorization of psychotropic medications for SKY Enrollees
- Process for peer consultation
- A process for periodically evaluating guidelines for continued appropriateness
- Performance measures with benchmarks to assess effectiveness

The Clinical Practice Workgroup will develop a plan for implementing guidelines that includes system wide education, dissemination of guidelines and ongoing monitoring. They will meet to continuously review the rate of prescribing psychotropic medications for SKY Enrollees, refine guidelines and determine the need for continued education and training.

As part of implementation, Molina will educate caregivers, DCBS Social Service Workers, Molina care coordinators, DJJ Social Workers, schools, and other stakeholders on the guidelines and other resources relevant to the use of psychotropic medication with SKY Enrollees.

DATA AND INFORMATION SHARING

An important factor that contributes to polypharmacy and the high rate of psychotropic medication prescribing practices is the lack of information sharing among the multiple systems and providers that serve children and youth. To address this issue, the Clinical Practice Workgroup will agree upon a standard data set and frequency of information sharing for shared Enrollees. They will consider including data such as medications, dosages, prescribing physician, diagnosis, type of placement and key contacts. Representatives from each organization's respective IT department will discuss the availability of such data, file transfer formats and other details. Molina will offer its secure Stakeholder portal as an option for sharing reports across participants to assure privacy. We will offer our advanced analytics capabilities to combine reports to enable Clinical Practice Workgroup participants to quickly identify unsafe or inappropriate practices such as a SKY Enrollee receiving psychotropic medications from multiple systems, prescribing psychotropic for very young children, and providers with outlying practices. They will also review for trends such as the rate of prescribing by placement or provider type. Together, they will determine the causes for identified trends and discuss appropriate actions, such as policy changes or training.

CLINICAL ROUNDS

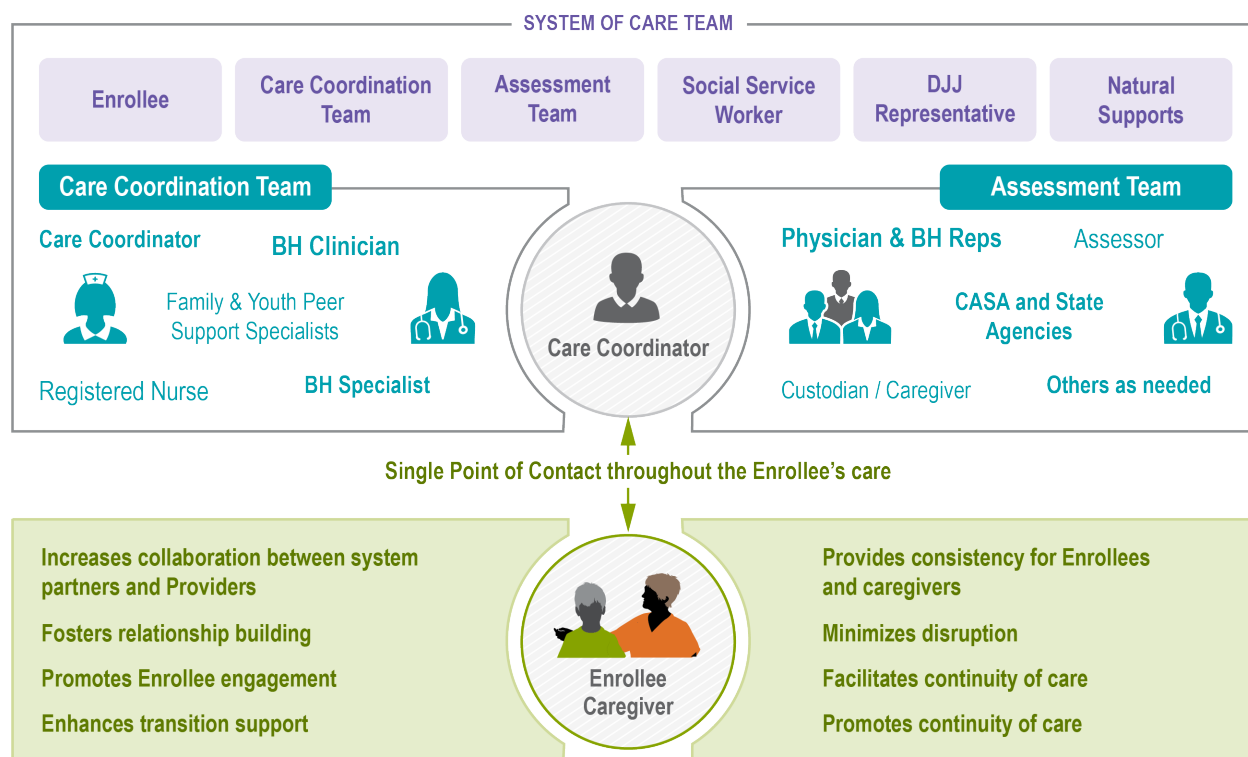
Clinical Practice Workgroup participants will design a clinical rounds process for shared SKY Enrollees with complex needs and those at risk for placement disruption. In our experience, psychotropic medications are often used as a method to reduce acting out behaviors that are difficult to manage, whether they are due to a behavioral health need, developmental disability or trauma-related response. We will work to support caregivers and system staff responsible for care coordination or case management (such as DCBS Social Service Workers, DJJ Social Workers, and others) by bringing together a cross-system team of experts to review the Enrollee's needs, develop solutions for addressing the problematic behaviors, and quickly implement interventions. Molina commits to immediately arranging for behavioral health, crisis, in-home, family support, and other services agreed to by participants without delay. Our goals are to assure Enrollees and caregivers have access to the services they need to promote permanency and avoid further trauma for the Enrollee.

b. DISCHARGE PLANNING ACROSS ALL LEVELS OF CARE

Molina puts the Enrollee in the center of all we do and works to engage both Enrollees and their caregivers as active participants in their healthcare when possible. We know from our national experience the value that system partners bring to the discharge planning process. Enrollees will be at risk of poor outcomes if managed care plans, system partners, and providers do not work together to provide holistic, wraparound supports to the Enrollee as they transition levels of care. Informed by our experience in serving children and youth in other programs, Molina will apply a collaborative discharge planning process for the SKY program. Through our System of Care approach, we will bring together the systems, providers, caregivers, and stakeholders (such as the Enrollee's court-appointed special advocate [CASA]) to create a coordinated plan for supporting the Enrollee during times of transition.

Central to our approach is Molina's care coordinator who will serve as the Enrollee's single point of contact from the time of enrollment and throughout their journey until disenrollment. As the Enrollee's needs or placement changes, our care coordinator will consult with internal experts and the System of Care Team to assure that the Enrollee's needs are being met while continuing to coordinate care. Maintaining a consistent point of contact for the Enrollee, caregiver, and system partners will facilitate continuity of care, promote consistency and reduce the trauma Enrollees experience when individuals come in and out of their lives. It also enables relationship-building and continued collaboration between Molina and system partners. Molina's care coordinator will serve as the hub for bringing together the Enrollee's System of Care Team and sharing information.

Our process will begin with collaborating with the Enrollee, caregiver, and DCBS Social Service Worker and/or DJJ Social Worker to define the participants for the Enrollee's System of Care Team, which will integrate the Care Coordination Team, Assessment Team and put the Enrollee in the driver's seat as shown in Exhibit G.11-1, System of Care, participants may change, as the Enrollee's needs change while always keeping the Enrollee at the center of the process.



246.KY19

Exhibit G.11-1. Molina’s System of Care Promotes Continuity for Enrollees and Caregivers

Molina’s System of Care model promotes permanency for Enrollees and caregivers. It will bring together the right team members at the right time to connect Enrollees to the right services and supports to meet their needs. This multidisciplinary approach will reduce the Enrollee’s risks for inpatient admissions and placement disruptions. However, we recognize that Enrollees will experience changes in level of care, placement and providers, some of which will come as a result of the Enrollee achieving goals and milestones—discharge to the community, return home, and transition to adulthood. For all transitions and discharges, Molina’s care coordinator will facilitate communication between the facility or treating provider and the System of Care team.

DISCHARGE PLANNING PROCESS

Molina’s Enrollee-focused discharge planning process will assure that Enrollees receive care in the right place with the supports they need to thrive. Specifically, our model addresses: planned admissions and transitions, emergent admissions, coordinating discharges with behavioral health providers, Enrollee-focused supports, notifying DCBS before decertification and follow up after discharge.

Planned Admissions and Changes in Level of Care

Planned admissions will begin with the System of Care Team determining the most appropriate setting to meet the Enrollee’s needs, identify interventions, establish goals for discharge and develop the discharge plan before the Enrollee’s admission. The care coordinator will document these decisions in the Enrollee’s integrated Care Plan, which will be available to System of Care Team participants through our cloud-based Health Backpack. Our care coordinator will maintain regular contact with the treating provider and Enrollee to assure that services are being delivered and to check on the Enrollee’s progress toward their defined goals. They will convene the System of Care Team virtually and in-person to update the Enrollee’s Care Plan and discharge plan, as needed to reflect the Enrollee’s current status and need for support.

Emergent Admissions

If an Enrollee experiences an unplanned or emergent admission, Molina will be notified by contracted hospitals. Caregivers and DCBS Social Service Workers or DJJ Social Workers participating on the System of Care Team will likely also contact our care coordinator, with whom they have a relationship. Upon notification of an Enrollee's admission, our care coordinator will take action to contact the hospital, caregiver and System of Care Team participants to gather information on the circumstances that led to the admission, check on the Enrollee's status and discuss discharge planning. They will visit with the Enrollee to gather a full understanding of the situation from the Enrollee's perspective to inform discharge planning. The care coordinator will convene the System of Care Team, which will include facility staff, in-person and virtually to create a discharge plan with the Enrollee that addresses: goals of discharge, level of care/placement, services and supports, providers, schooling, medications, Enrollee and caregiver education, peer support, transportation and medical record transfer.

Throughout the Enrollee's admission or facility-based stay, Molina's care coordinator will meet with the Enrollee, communicate with and convene the System of Care Team and update the discharge plan. Before the Enrollee's discharge, the care coordinator will collaborate with the System of Care Team to make sure that services and supports are in place and ready to begin on the day of discharge.

Discharge Planning with Behavioral Health Providers

Our care coordinators will involve behavioral health providers and case managers as System of Care Team participants in discharge planning meetings to assure compliance with federal Olmstead and other applicable laws. As part of the System of Care Team, they will create an appropriate discharge plan focused on making sure that needed supports and services are available in the least restrictive environment to meet the Enrollee's behavioral and physical health needs, including psychosocial rehabilitation and health promotion. Our care coordinator will confirm that the Enrollee has access to behavioral health follow-up services and community supports that effectively meet Enrollee's needs. Additionally, they will collaborate with behavioral health providers to assist Enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program or other similar assistance programs.

We will work to prevent emergency department (ED) visits, admissions, and readmissions for Enrollees with acute behavioral health needs by partnering with community mental health centers (CMHCs) to provide the most effective service at the right level of care. We will leverage our partnerships with CMHCs to build an Intercept Program, a centralized process for scheduling appointments following a behavioral health inpatient discharge. These appointments are essential to giving Enrollees significant support during discharge because the risk for re-admission for Enrollees leaving an inpatient facility is high.

Enrollee-focused Support During Transitions

When supporting Enrollee transitions, Molina's care coordinators will have the benefit of having a complete picture of the Enrollee based on the relationship built from the time of enrollment in the SKY Program. They will understand what works for the Enrollee and what doesn't work, supports that will be important for the Enrollee during transitions, how the Enrollee responds to traumatic events such as a change in placement, natural supports and others involved in the Enrollee's life.

Our care coordinators will rely on their knowledge of the Enrollee to provide the right type of supports during transitions. For example, they may arrange for the Enrollee to visit or view pictures of a new home or placement or meet new providers before discharge to ease their anxiety; arrange for peer support services during the transition; or make sure that the Enrollee has certain items that are important to them, such as pictures, a special toy, or other item. Maintaining consistency in care coordinators allows us to offer a personalized touch that reduces trauma and anxiety for SKY Enrollees.

Molina's discharge plans will incorporate a crisis plan that clearly outlines symptoms or signs to watch out for, step-by-step instructions on how to handle certain situations (such as missed medications,

behavioral outburst), the number for our Nurse Advice Line for medical concerns, our behavioral health hotline, and other supports the caregivers can contact. The care coordinator may schedule training for the Enrollee's caregiver on how to administer medications, use durable medical equipment, identify an increase in symptoms and mitigate crisis situations.

Notification Before Decertification

To enhance continuity of care and make sure the parties involved in the Enrollee's care have the information needed to best serve the Enrollee, the care coordinator will notify the Department and DCBS before decertification of a child or youth in Foster Care for services in an in-state hospital or residential facility at least three days before the decertification; and at least seven days prior for foster children receiving hospital or residential services in an out-of-state facility, as required by Attachment C, Draft Medicaid Managed Care Contract, Section 42.10.5, Prior Authorization and Pre-Certification. We understand that written documentation of an upcoming Medical Necessity review does not qualify as a decertification notice. Clinical Care Advantage, our care management documentation system, will alert the care coordinator to complete the notification as part of the decertification process. As part of our ongoing collaboration with the Department, we will determine methods for providing notifications electronically, creating an efficient and effective process that minimizes administrative burden for the Department.

Implementing the Discharge Plan

Before the Enrollee's discharge, the care coordinator will schedule follow-up appointments (PCP, behavioral health, and specialists), arrange for medications and durable medical equipment, and transfer medical records. The care coordinator will collaborate with the System of Care Team to make sure that services and supports are in place and ready to begin on the day of discharge.

The discharge plan will include scheduled System of Care Team meetings, which the care coordinator will convene. Team meetings will usually occur within seven days after the Enrollee's discharge—for some Enrollees it may occur sooner and others may meet later, depending on the Enrollee's personal circumstances. The team will verify the appropriateness of services and supports and update the Enrollee's Care Plan, as needed. Molina's care coordinator will contact the Enrollee daily, if needed, for the first week after discharge and that at a frequency determined by the System of Care Team to make sure that services and supports are in place and continue to support the Enrollee in meeting their established goals.

COLLABORATING WITH STATE OPERATED AND CONTRACTED HOSPITALS

Upon contract award, Molina will enter into a collaborative agreement with the State operated or State contracted psychiatric hospital in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. The agreement will detail responsibilities of the behavioral health service provider regarding continuity of care for successful transition back into community-based supports. In addition, Molina's behavioral health providers will participate in quarterly Continuity of Care meetings hosted or operated by the Department or State contracted psychiatric hospital. This policy will enhance care coordination between systems and will make sure there are no gaps in an Enrollee's care.

Discharge Planning Audits

To measure the effectiveness of our discharge planning, Molina will conduct discharge-planning audits to assess:

- Timeliness of contacts with DCBS, DJJ caseworkers, and caregivers
- Placement status calls
- Post-discharge follow-up calls
- Follow-up assessments within seven and 30 days of discharge
- Completion and distribution of discharge summary
- Medication pick-up reminders to caseworkers and caregivers

If monitoring or audit results indicate that a care coordinator is not completing functions in a timely manner, the supervisor will educate the care coordinator on requirements, and take corrective action as needed, such as additional training or more frequent monitoring until performance meets goals and standards. The supervisor or designee will compile findings from monthly Clinical Care Advantage reports and audits. These reports will summarize records and staff reviewed, overall score, and improvement areas. The supervisor will use the report to identify departmental training needs and confirm that the number of care coordinators is adequate to meet Enrollee's needs. The supervisor will send the report to our Quality Improvement Committee to identify and address improvement needs and inform the Program Annual Evaluation.

Page intentionally left blank