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.

The goal of the foster care system is to promote the well-being of children and adolescents by providing for their health, safety, well-being and permanency. There has been increasing alarm over psychotropic medication use for children and youth in foster care across the country. Given the rates of psychotropic drug use among children in foster care, there is a growing concern that these medications may be taking the role of an easy fix in managing care, and the results can be tragic. Trends in psychotropic medication usage of serious concern include the practice of numerous drugs being prescribed in combination, and these powerful medications being prescribed for very young children. At the same time, medications properly administered and thoughtfully prescribed as part of an evidence-based, appropriate overall treatment program can help a child or youth in need.

We know from our experience serving children and youth served in foster care, adoption assistance, transition aged youth and juvenile justice programs that they are prescribed psychotropic medications at a rate up to four times that of their peers in the CHIP/TANF population. To address this trend, we have developed a five-pillar strategy for addressing the prescribing of these drugs to children presented in the table.

Five Pillars for Addressing the Prescribing of Psychotropic Medications
Change Prescriber Habits
Our SKY provider liaison will meet with and train PCPs and child psychiatrists about alternatives to prescribing psychotropic medications. This may include training them on how to refer a child, youth or their caregivers to immediate behavioral health treatment to address the child's trauma.
Training and Education for Prescribes and Stakeholders
We offer free education to providers through OptumHealth Education, which offers courses related to psychotropic medications. For instance, the *Caring for Children in Foster Care: Psychotropic Medication Overuse* course discusses the appropriate and inappropriate use of psychotropic medication and the safety and efficacy of these medications among children and youth in foster care.
Network Enhancement
We will have a network of providers who can provide crisis support to keep children in family homes with support instead of using these medications. The use of telemental health will provide assistance to having children get the treatment they need with timely access, outcome based contracting to reduce the use of these medications. Will use telepsychiatry and psychiatry consults for PCPs, when, needed to reduce the use of pharmacy when behavioral health treatment is needed.
Pharmacy Reviews
We have a network of trained clinical pharmacists who specialize in the review of children on psychotropic medications. Our clinical team, working with the pharmacist, will review case-specific information about children who are on psychotropic medications to determine if outreach to the provider is warranted. If our clinical pharmacist reviews a child's medication, our clinical team will reach out to the DCBS caseworker, DJJ prescribing physician, and foster parent to discuss the review and results.
Thought Leadership
We will provide literature and information to our provider network about the effects of using these medications for children in foster care. For example, we link teams to research and study results from other states on their efforts to reduce the trend of over prescribing these drugs, and will discuss with DCBS, DJJ, and sister agencies how we can use the lessons learned when developing our strategic plan.

Our experience has shown us the pharmacy reviews of children already on psychotropic medications is a key component to the strategy, and the subsequent outreach to the provider

has shown results in assisting with reducing medication overuse, and increasing adherence. We use the following criteria to conduct a file review of medication and medication reconciliation by a clinical pharmacist:

Topic	Activities
Pharmacy Consult Guidelines	Children and Youth in Foster Care will have a clinical pharmacy review if there are: ▪ Rejected claims ▪ Benefit questions ▪ Medication access issues ▪ Side effects ▪ Drug information ▪ Prior authorizations ▪ Prescription script limits ▪ Potential psychotropic medication misuse
Examples of Pharmacy Referrals with Potential Impact	▪ A child, youth, foster parent, or DCBS worker is expressing a pharmacy issue: ● Examples include: benefit questions/trouble, access issues, over medication ▪ Admits and ED visits combined with any condition that is highly dependent on medication therapy ● Examples include (but are not limited to): Asthma and respiratory diagnoses, Diabetes, cardiac conditions and behavioral health conditions ▪ The pharmacist will work with the member and provider on medication therapy optimization ● Quality ▪ Three major conditions that have HEDIS metrics related to pharmacy are: ● Asthma ● Diabetes ● Behavioral Health – Psychotropic Medication ▪ A clinical pharmacist will review every child case where: ● A child under 3 years of age is prescribed an anti-psychotic ● A child age 0-6 is prescribed a psychotropic medication ● Any child prescribed more than 1 antipsychotic medication ● Any child prescribed more than 4 psychotropic medications

After the clinical pharmacist review, they will notify the care team of the need for an interdisciplinary care team meeting or clinical rounds regarding the findings with the care coordinator, SKY behavioral health specialist, SKY provider liaison, and the nurse care manager to discuss the findings and plan for outreach. Upon go-live, we will implement a strategic plan to gather and stratify the data and initiate data reviews based upon our algorithm. Following are examples from our clinical pharmacy reviews that occur for children in foster care programs from the other states we serve:

- Medication review of prescribing for a 16-year-old female in foster care with diagnoses of major depressive disorder and PTSD revealed that the provider was tapering up trazodone from 50mg tablets once daily, to 75mg and finally 100mg tablets once daily. The member's caregiver continued to fill both strengths, so the member was using 175mg daily, which is more than the maximum recommended off-label dose of 150mg. The clinical pharmacist reached out to the provider's office and spoke with nurse to verify the medication was not being properly administered. The clinical pharmacist recommended to the provider that the nurse contact the pharmacy with a new

prescription for the correct dose and have all other prescriptions for trazodone closed so they are not filled in error.

- Medication review of prescribing for a 9-year-old male in foster care with diagnoses of Fragile X, Autism and ADHD revealed a member taking both risperidone and aripiprazole for irritability associated with autism, which is therapy duplication. The aripiprazole had been approved and, according to the paperwork, the risperidone should have been discontinued more than2 months earlier. The clinical pharmacist reached out to the provider's office and spoke with a nurse to confirm risperidone had been filled two times after discontinuation. During the call, the clinical pharmacist asked the nurse to contact the pharmacy to close the risperidone prescription. There have been no refills since the outreach.
- Medication review of prescribing for a 12-year-old female in foster care with diagnosis of Disruptive Mood Dysregulation Disorder (DMDD) discovered she was taking both risperidone and aripiprazole for DMDD, which is therapy duplication. The aripiprazole was authorized and started 4 months before for aggression while hospitalized. When the member discharged from the hospital, both medications were continued in error. The clinical pharmacist reached out to the outpatient psychiatric provider office and spoke with a nurse who clarified the member was not to be on aripiprazole because she did not respond well to it and each time the member discharges from the hospital, they have restarted aripiprazole. During the call, the clinical pharmacist asked the nurse to call the pharmacy to discontinue the aripiprazole and request the pharmacy notify the office if a different provider prescribes a new behavioral health medication. There have been no refills of aripiprazole since the outreach.

DUR Board Committee

Our UnitedHealthcare Drug Utilization Review (DUR) Board is responsible for developing, maintaining and providing medical oversight of drug -utilization review programs used by Medicaid benefit plans issued or administered by UnitedHealthcare or its affiliates in accordance with the requirements of a DUR Board in 1927(g) of the Social Security act relating to DUR activities. Our board will review the Commonwealth's Preferred Drug List, and will work with DMS on any recommendations related to age limits on psychotropic drug classes, guidance for off label use and any special tracking DMS requires. The board will then monitor these nuances through data trend reviews and make recommendations for changes based upon this review. The membership of the DUR Board includes health care professionals who have recognized knowledge and expertise in one or more of the following:

- The clinically appropriate prescribing of covered outpatient drugs
- The clinically appropriate dispensing and monitoring of covered outpatient drugs
- Drug use review, evaluation and intervention
- Medical quality assurance

The DUR Board provides clinical support for developing, maintaining and providing clinical oversight of drug-utilization review programs and the pharmacy lock-in program. This support verifies our clinical pharmacy programs improve quality of enrollee care by promoting safety, identifying gaps in care, and reducing the frequency of patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists and health plan enrollees.

Tracking Performance Against Key Performance Indicators

Our clinical leadership team continually analyzes data at the population, provider and facility level and compares our performance to nationally recognized standards (e.g., HEDIS) and key performance indicators using a suite of advanced data analytics tools. We use these analyses to evaluate the ongoing effectiveness of our clinical programs, monitor utilization patterns and identify trends and opportunities for improvement to verify we are delivering positive outcomes in terms of quality of care, enrollee experience, outcomes, quality of life and cost of care. The table presents key performance indicators related to the use of psychotropic medications.

Key Performance Indicators Related to Psychotropic Medications			
Outcomes	**Measured Metric**	**Goal**	**Source**
Reduce the number of children under the age of 6 receiving a psychotropic medication	Number of children under the age of 6 receiving a psychotropic medication (codes in appendix)	Less than 1% of population	Claims Data
Reduce the number of children receiving more than one antipsychotic	Number of children under the age of 18 receiving more than one antidepressant at the same time	Less than 2% of the population	Claims Data/HEDIS
Reduce the number of children under the age of 3 receiving an antipsychotic	Number of children under the age of 3 receiving an antipsychotic medication	Zero children	Claims Data
Reduce the number of children receiving more than four psychotropic medications in 1 month	Number of children under the age of 18 receiving more than four psychotropic medications in 1 month	Less than 1% of the population	Claims Data

Educating Providers about Psychotropic Medication

We offer free education to providers through OptumHealth Education, accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education and the American Nurse Credentialing Center, providing education for providers through live and on-demand education. Providers can earn continuing education credits for participation. Providers can participate in training on a variety of subjects related to children and adolescents in foster care, including education about implementing a Trauma-informed approach. OptumHealth Education offers courses related to psychotropic medications. For instance, the *Caring for Children in Foster Care: Psychotropic Medication Overuse* course discusses the appropriate and inappropriate use of psychotropic medication and the safety and efficacy of these medications among children and youth in foster care. It discusses why there is a high rate of overtreatment with psychotropic medications for children in the foster care system, how to prevent it, and it covers how psychotropic medications can change brain chemistry in children 0 to 12 years of age and identifies alternative therapies that can be used instead of 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.

Our discharge-planning program complies with Attachment C – Draft Medicaid Managed Care Contract, 42.10.3 Discharge Planning. Inpatient admissions are times of great vulnerability for children and youth in the SKY program. To help manage these transitions between care settings, we have implemented a core discharge planning approach. This approach includes methods to identify children and youth experiencing an inpatient admission, qualified personnel to support the discharge planning effort, appropriate assessment tools, care management tools

that promote collaboration among multidisciplinary care team (MCT) participants and share enrollee data to inform and support a comprehensive discharge planning process.

We use a variety of means to identify enrollees experiencing an inpatient admission in a variety of ways. These can include enrollee notifications, DMS, DCBS or DJJ notifications; admit, discharge and transfer (ADT) alerts; notifications from other UnitedHealthcare departments, such as NurseLine; daily census reports from our hospital partners; and utilization management (UM) reporting, such as daily tracking of children or youth who have been admitted to a hospital.

Discharge planning begins when the enrollee is admitted to the hospital. The child's or youth's care coordinator or complex care nurse care manager collaborates with an inpatient care manager (ICM) from our UM team and the child or youth, facility staff, DMS, DCBS or DJJ staff, the foster family and anyone the child or youth and family chooses to participate to develop a discharge plan. The plan identifies the services and supports to sustain the progress the child has made during the inpatient stay after discharge so the enrollee can live in the safest, least restrictive setting of their choice. The discharge plan builds on the child or youth's strengths and identifies the services and supports that meet their needs and help them achieve their goals. The planning process, presented in the figure, improves outcomes by anticipating post-discharge issues and identifying interventions to mitigate them.

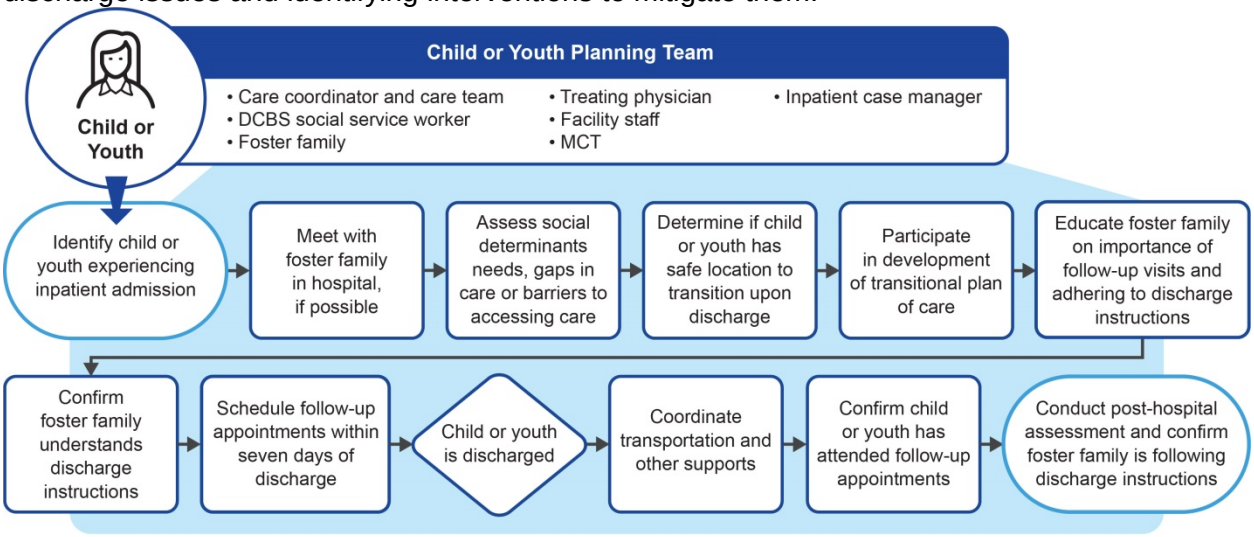

Figure 18. Discharge Planning. Discharge planning begins once we become aware of an enrollee's admission. During their inpatient stay, we comprehensively assess the enrollee's post-discharge needs and goals and support the development of a discharge plan that deploys comprehensive services and supports to meet those needs and goals. The plan helps to prevent readmissions by anticipating post-discharge issues and implementing interventions to mitigate them.

Collaborating with DMS, DCBS and DJJ

All too often, those served through the complex foster care system get bogged down in the number of details and responsibilities to achieve permanency. We do not want to add to the confusion, but rather use our system to better enhance the care for children and families DCBS and DJJ are supporting. We will staff care coordinators in each of the nine DCBS service regions. This will allow our care coordinators to develop working relationships with DCBS staff so we can more readily meet the needs of enrollees, particular those children and adolescents with urgent needs or who are in crisis. Additionally, SKY behavioral health specialist will work with DMS, DCBS and DJJ staff to understand changes to the foster care system, resolve issues and confirm our care coordinators and our entire SKY team understands changes that may affect their daily work.

The Care Coordinator

To reduce complexity for children and youth in foster care,and those supporting them, our care coordinator serves as the ***primary point of contact to coordinate care*** and help them navigate the health care system. For children who are medically complex, the nurse care manager will serve as the primary point of contact for the child, youth and their caregivers. We maintain the relationship between each enrollee and their care coordinator, regardless of placement changes to provide stability for the child and their foster family and allow the child and their care coordinator to establish a trusted relationship. Establishing trust is the first step in helping each child or adolescent in foster care participate in their care and navigate the health care system. The care coordinator will engage with the child's or youth's MCT, DMS, DCBS and DJJ to address concerns related to discharge planning.

Our care coordinators are accountable for managing the entirety of the child's needs with minimal handoffs and providing a consistent point of contact for the child or youth, their foster parents and their MCT. For instance, DCBS develops a Case Plan document that provides information related to the child's permanency goal, goals related to well-being and an inventory of any court ordered services that we can assist DCBS in coordinating, especially related to Medicaid covered services such as therapy, assessments and medical appointments. The care coordinator will work with the DCBS social service worker to obtain the enrollee's Case Plan and incorporate it into enrollee's discharge plan.

SKY Behavioral Health Specialist

Our SKY behavioral health specialist is the primary point of contact for DMS, DCBS, DJJ and sister agencies. They will have expertise in the foster care and DJJ systems and DMS, DCBS and DJJ policies and procedures. They will develop relationships with DMS, DCBS, DJJ and sister agencies. As requested, they will participate for meetings, strategy sessions, conference planning and joint trainings. They will help address concerns and understand how system issues will affect our care coordinators, providers and community organizations. The SKY behavioral health specialist will educate our full SKY team so they understand the nuances of the work they do and when DCBS makes changes to the SKY program. The specialist will work throughout the Commonwealth to learn about the community-based resources available to SKY enrollees. They will meet with nonprofits, faith-based organizations and other community members to understand their mission, strategy, capabilities and expertise, build relationships and determine the extent of future partnerships with community resources.

Collaborating with Hospitals

The inpatient case manager from our UM team works with the treating physician, hospital discharge planner and other hospital staff to promote the continuity of the enrollee's care, confirm an appropriate level of care, manage length of stay and support the discharge planning process. As presented in the figure, an inpatient case manager determines if the admission requires prior authorization and, if so, processes it through our prior authorization process. The inpatient case manager uses Milliman Care Guidelines to help support the discharge planning process and evaluate an appropriate level of care for the enrollee upon discharge. During the enrollee's hospital stay, the inpatient case manager confirms the enrollee is receiving an appropriate level of care until they are ready for discharge.

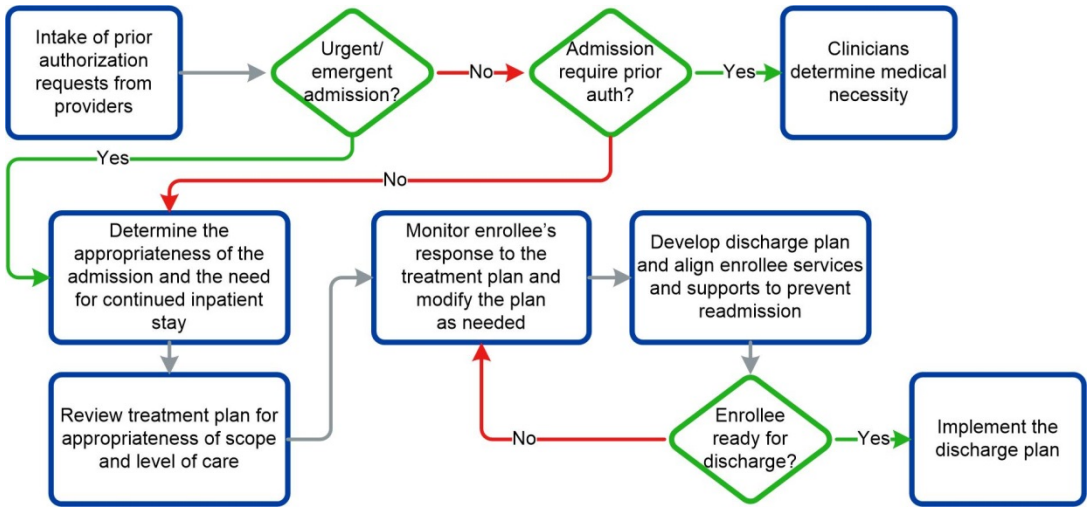

Figure 19. Collaborating with hospitals. Upon notification of a non-emergent inpatient admission, UM clinicians determine if the admission requires prior authorization. If so, they determine the appropriateness of the admission and the need for a continued inpatient stay. During the member's inpatient stay, the UM clinician reviews the treatment plan for appropriateness and scope and the member's response to the treatment plan and begins discharge planning.

Collaborating with PRTFs

During discharge planning, the enrollee's care coordinator will engage the behavioral health provider where the enrollee's step down from the PRTF will occur. To ease the enrollee's step down, the care coordinator will engage peer navigator and peer supports to work with the enrollee while they are in the PRTF. The peer will help the child or youth access My Whole Health Tracker to help them manage their conditions, such as behavioral health symptoms, recovery from substance use, coping with triggers and preparing for emergencies. My Whole Health Tracker helps enrollees identify their strengths and opportunities in 10 health lifestyle domains. These plans help guide each enrollee's choices to get well, stay well and make their life the way they want it to be. WRAPs include a daily maintenance plan, a crisis plan and post-crisis activities to provide youth with tools to continue their recovery despite setbacks. The care coordinator may also arrange for the enrollee to visit the step down location to help them acclimate to the change.

Available through *myuhc.com*, our Whole Health Tracker is an evidence-based self-management tool that addresses healthy eating, managing stress and physical activity to help enrollees reach whole health, wellness and resiliency goals through effective self-care. It allows enrollees to create a WRAP, and set and actively work on goals in 10 domains of wellness.

Our care coordinators and provider relations team develop relationships with agency, foster parent, or parent to whom the child is discharging. They will help to coordinate all outpatient services for the child once they are going to be discharged. They also will be the single point of contact if there is a gap presented in the discharge plan that needs filled. For example, the PCP does not have appointment availability within the week the child is discharged.

Collaborating with Residential Providers

The enrollee's care coordinator will visit with residential providers to discuss key issues affecting UnitedHealthcare enrollees living in their facilities, confirm the delivery of services to the enrollee and that the environment is appropriate to the enrollee. The care coordinator will participate in discharge planning and team meetings to support the enrollee's discharge from the residential facility to their new location. The care coordinator may arrange for the enrollee to visit their new location to help them acclimate to the change. The care coordinator also will

connect the enrollee to peer supports who will support the enrollee's move; including helping them develop a WRAP.

Collaborating with Physical and Behavioral Health Providers

The care coordinator alerts the enrollee's physical and behavioral health providers to their inpatient admission. They gain the enrollee's agreement to include these providers in the discharge planning process to help identify the services and supports the enrollee will need to confirm the progress the enrollee has made during the inpatient stay continues after discharge and the enrollee can live in the safest, least restrictive setting of their choice. Upon discharge, the care coordinator alerts the enrollee's physical and behavioral health providers to their discharge. They work with the enrollee and their providers to confirm the enrollee attends follow-up appointments.