



Molina Healthcare of Nebraska

Overview

- Care & Complex Case Management
- Specialty Care Positions & Roles
- Collaboration with Utilization Management
- Key Clinical Programs
- Contact Information & Referral Process



Care & Complex Case Management

Levels of Case Management Services at Molina

Molina Case Managers are nurses, licensed behavioral health (BH) professionals, and social workers who conduct health risk assessments—by phone or in person—to identify member needs and develop individualized care plans.

These care plans are created in collaboration with the member, using both their identified goals and medical history to guide interventions and support services.

All Nebraska Medicaid members are eligible for Case Management (CM). The level of support is based on the member's unique health conditions and risks:

Disease Management

Focuses on health promotion and chronic disease prevention. Designed for members with low-acuity conditions who are at risk for future complications.

Care Management

Supports members at high risk for re-hospitalization after discharge. This includes care coordination, education, and access to services like Long-Term Services and Supports (LTSS).

Complex Case Management

For members experiencing significant health events or serious diagnoses that require high levels of support. The goal is to help members navigate the system, improve function, and regain stability in a cost-effective manner.

Molina Healthcare Case Management

Molina's Case Management Program is a collaborative, member-centered approach designed to:

- Support individuals in meeting their health goals
- Improve quality of life
- Achieve cost-effective, coordinated care outcomes

We use a multi-disciplinary team model, tailored to each member's needs and preferences. The care team may include:

- The member and their caregiver or representative
- The member's Primary Care Provider (PCP)
- Molina Medical Director
- Molina Dental Team (*if applicable*)
- Case Manager
- Molina Pharmacist
- Behavioral Health Specialist
- Social Worker (Molina or external)
- Community Connectors or Nurse Practitioners providing in-home assessments
- Any provider involved in the member's care who can offer insight or support

Together, we work to ensure coordinated care and better health outcomes for every member.

Complex Care: Comprehensive Care and Case Management

Collaboration with Waiver Services

Active collaboration in the application process and with service coordinators. Coordinating Care Conferences with the member or designee, service coordinators, providers, and community supports.

Age-Appropriate Assessments and Medication Reconciliation

Completion of thorough assessments and medication reconciliation to tailor care plans to each person's, bridging gaps in care effectively.

Clinical Pharmacist Referrals

Referrals to clinical pharmacists for medication concerns, ensuring optimal medication management and addressing any related issues.

Provider Coordination Assistance

Assisting in locating suitable healthcare providers, ensuring accessibility to necessary healthcare services.

Addressing Social Determinants of Health

Identification and linkage to community resources to address social determinants of health.

Reassessment Following ER Visits or Hospitalizations

Completion of reassessments post-emergency room visits or hospitalizations, prioritizing follow-up appointments with providers and medication reconciliation.

Specialty Care Positions & Teams



Specialty Positions Provide Collaborative Support

Specialty roles that provide focused support and coordination based on members' unique needs and circumstances.

- Substance Use Disorder (SUD) Navigator
- Child Behavioral Health Specialist
- Employment Specialist
- Housing Specialist
- Justice Liaison
- Home and Community Based Service (HCBS) Waiver Liaison
- Rural Health Specialist
- Foster Care Liaison
- Community Connectors
- Dental Coordinator



Collaborative Support from Specialty Team Members

Justice Liaison

- Supports members in navigating legal and community resources to address justice-related needs.
- Facilitates care coordination and reentry support following incarceration.

SUD Navigator

- Assists members with substance use disorders in accessing treatment and recovery supports.
- Connects members to appropriate clinical and community-based SUD resources.

Employment Specialist

- Supports members in obtaining and sustaining employment aligned with their skills and goals.
- Connects members to vocational training, job placement resources, and employment supports.

Housing Specialist

- Connects members to housing assistance programs, emergency shelters, & long-term housing resources.
- Conducts face-to-face visits at metro-area shelters to support members experiencing housing insecurity.

HCBS Waiver Liaison

- Connects member to Home & Community-Based Services and related support programs.
- Coordinates with care teams to ensure members receive timely & appropriate long-term care services.

Rural Health Specialist

- Supports members in rural communities by identifying & addressing gaps in access to care.
- Provides solutions to overcome challenges related to distance, transportation, & provider availability.

Foster Care Liaison

- Assist foster children & their caregivers in navigating healthcare, BH, & community-based resources.
- Facilitates care coordination in collaboration with child welfare agencies & providers.

Community Connectors

- Engage members in their homes or communities to foster trust and improve care engagement.
- Identify and address SDoH needs while supporting coordination of healthcare & social services.

Child Behavioral Health Specialist

- Support youths receiving care in Psychiatric Residential Treatment Facilities (PRTFs).
- Coordinates BH services & transition planning for youths to ensure continuity of care across settings.

Dental Coordinator

- Collaborates with Case Management to identify & connect members with appropriate dental homes.
- Coordinates dental care services to ensure timely access & address member's oral health needs.

Community Connectors

Connecting Members to Care and Community Resources

Community Connectors (CCs) serve as trusted advocates and liaisons between members and the health care system. As community-based professionals, CCs use their deep knowledge of local resources and cultural insight to:

- Engage and build trust with vulnerable members
- Help members navigate health care and social services
- Promote preventive care and support chronic condition management
- Advocate for member needs and reduce barriers to care
- Collaborate with the care team to improve health outcomes

CHWs play a vital role in supporting whole-person care by addressing both medical and non-medical drivers of health—such as housing, transportation, and food access.

Collaborates and Supports

Provides Non-medical, paraprofessional needs. Meeting in the individual's homes, nursing homes, shelters, doctor's offices, etc.

Advocates and Empowers

Assists in navigating and maximizing health plan benefits, scheduling appointments, arranging transportation for healthcare visits, getting prescriptions filled, and following up on missed appointments

Addresses SDOH needs

Assists in accessing social services, community-based resources for housing, food, employment, etc.

Provides Outreach

Conducts research to locate members that Molina has been unable to contact. Participates in ongoing or project-based activities, at times requiring extensive member outreach.

Home and Community-Based Services (HCBS) Team

Overview

- Supports members with disabilities, chronic conditions, and long-term care needs
- Promotes independent living through access to home and community-based services

Key Responsibilities

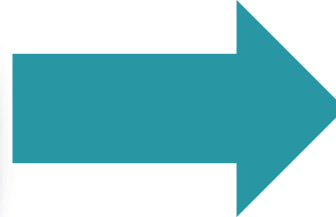
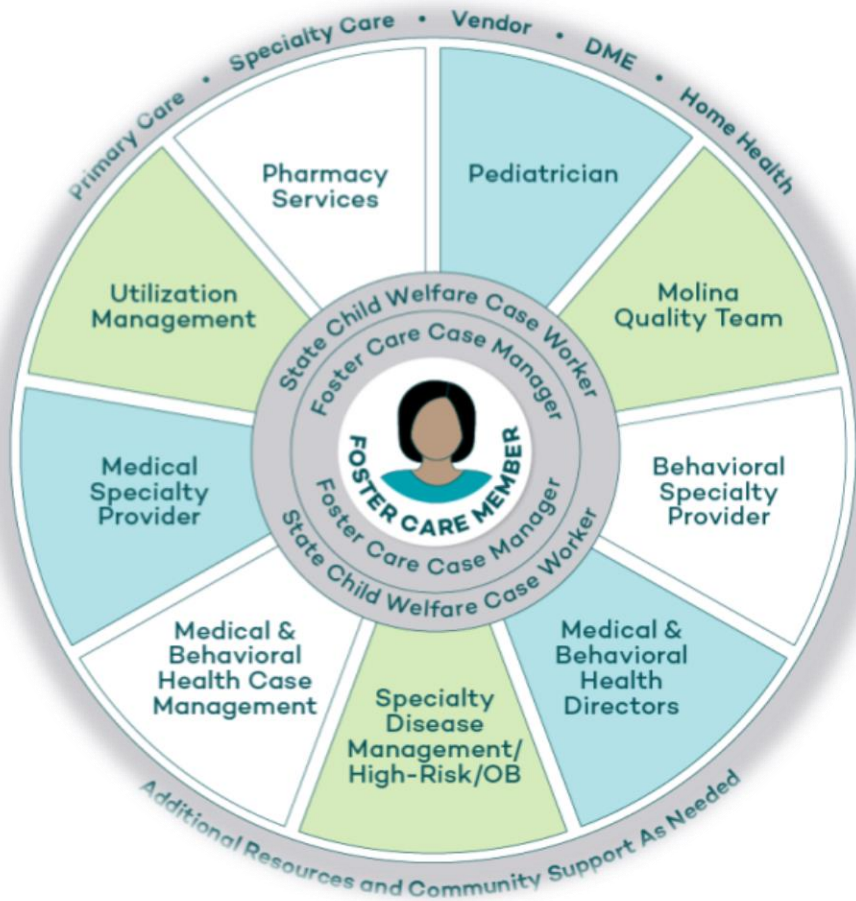
- **Personalized Care Planning**
Develops individualized care plans that reflect member goals, preferences, and support needs
- **Collaboration with Service Coordinators**
Partners closely with state and community-based Service Coordinators to align care
- **Resource Navigation**
Connects members to long-term services and supports (LTSS), including personal care, adult day services, and home modifications
- **SDoH and Safety Focus**
Addresses barriers such as housing, transportation, and caregiver support
- **Ongoing Monitoring**
Provides regular follow-up to assess progress, adjust care plans, and support stability

Goal

- Help members remain safely in their homes and communities while improving quality of life and autonomy



Foster Care Team



Care Responsibilities

Molina Care and Case Manager

- Serves as the primary contact at Molina, coordinating care with interdisciplinary team members.
- Provides educates on medical conditions, recommended screenings, lifestyle changes, referrals, and community resources.
- Continuously evaluates and addresses gaps in care, with a focus on Social Determinants of Health (SDoH), member safety, and long-term stability.

Transition & Support Services for Foster Youth

- Conducts comprehensive assessments with youth and Child and Family Services Specialists to develop individualized, wrap-around service plans.
- Offers continued support for up to 12 months post-transition, promoting independence and connection to needed services.
- Delivers education and case management for former foster youth who are adopted or reunified with family.

Transition Preparation

- Builds trusting relationships with youth approaching transition age to support a smooth and successful move to adulthood.

Maternity & High-Risk OB Case Management

Overview

Supports pregnant members across all stages of pregnancy
Focused interventions for high-risk conditions to improve maternal and infant outcomes

Key Responsibilities

- **Early Identification & Risk Stratification**
Uses claims, referrals, and predictive tools to identify pregnancy and risk level
- **Personalized Care Planning**
Tailors care plans to member history, SDoH, and identified health needs
- **Care Coordination**
Connects members to OB care, PCP, BH, WIC, transportation, and housing support
- **High-Risk OB Management**
Offers intensive support for conditions like gestational diabetes, preeclampsia, or history of preterm labor
- **Education & Member Support**
Provides prenatal education, postpartum support, safe sleep guidance, and family planning resources
- **Postpartum Follow-Up**
Encourages timely postpartum visits and ongoing maternal health monitoring

Goal

- Promote healthy pregnancies, reduce complications, and support long-term wellness for mother and baby



Behavioral Health Case Management



Overview

- Supports members with mental health and substance use needs
- Promotes access to timely, coordinated behavioral health services

Key Responsibilities

- **Member Engagement**
Builds trust and supports members through outreach, education, and goal setting
- **Comprehensive Assessments**
Identifies behavioral health needs, safety risks, and social determinants of health (SDoH)
- **Care Planning & Coordination**
Develops individualized care plans and connects members to therapy, psychiatry, and substance use treatment
- **Collaboration with Providers**
Works closely with behavioral health providers, PCPs, and community resources
- **Crisis Support**
Coordinates crisis intervention services and safety planning when needed
- **Recovery & Wellness Focused**
Encourages long-term recovery through empowerment, education, and consistent follow-up

Goal

- Improve behavioral health outcomes by ensuring members receive integrated, person-centered care

Collaboration with Utilization Management



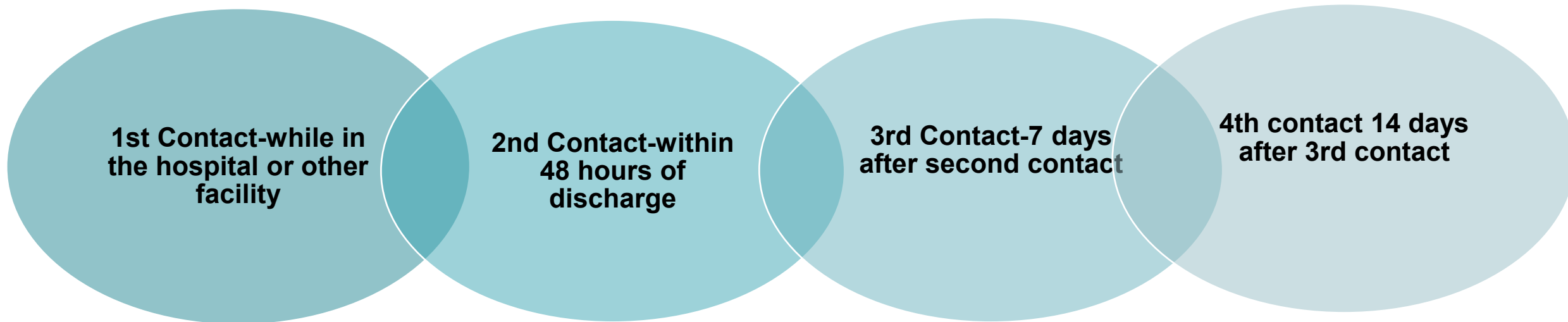
Transition of Care (TOC) Program

Transitions of Care (TOC) occur when a member moves from one health care setting to another—most often during or following an acute health episode. This includes transitions to or from Indian Health Services (IHS) or other tribal facilities. Molina's TOC Program supports members during this critical period by assigning a Case Management (CM) team member who provides close follow-up for at least the first 30 days post-discharge. The CM and Utilization Management (UM) teams collaborate closely to ensure that the member's medical, behavioral, and social needs are identified and addressed quickly and effectively.

Standard Contact Schedule:

- Initial outreach within 24–48 hours of discharge
- Follow-up check-ins at key intervals during the 30-day period
- Additional outreach based on the member's acuity and individual needs

The goal of TOC is to reduce avoidable readmissions, promote medication adherence, and ensure safe, coordinated recovery.



Integrated Care Coordination: UM & CM Collaboration

Care Coordination Between Utilization and Case Management

Daily Utilization Management Rounds

- Focus on members with current inpatient admissions
- Attended by UM, CM, and Medical Directors
- Promote real-time updates, discharge planning, and continuity of care

Discharge Planning Rounds

- Focus on members with complex medical needs
- Collaborative planning between UM, CM, Medical Directors, and specialists
- Addresses medical, behavioral, and social needs

Multidisciplinary Rounds

- Rounds and meetings are coordinated by the CM team
- Invitees may include:
 - UM and CM staff
 - Medical Directors
 - Behavioral Health and Dental Providers
 - Member's PCP or other community providers
 - The member and their caregiver or representative

This collaborative approach ensures that each member receives comprehensive, personalized care that supports their recovery, independence, and long-term well-being.

Key Clinical Programs



Care Connections Program Overview

Care Connections: Extending Access and Support

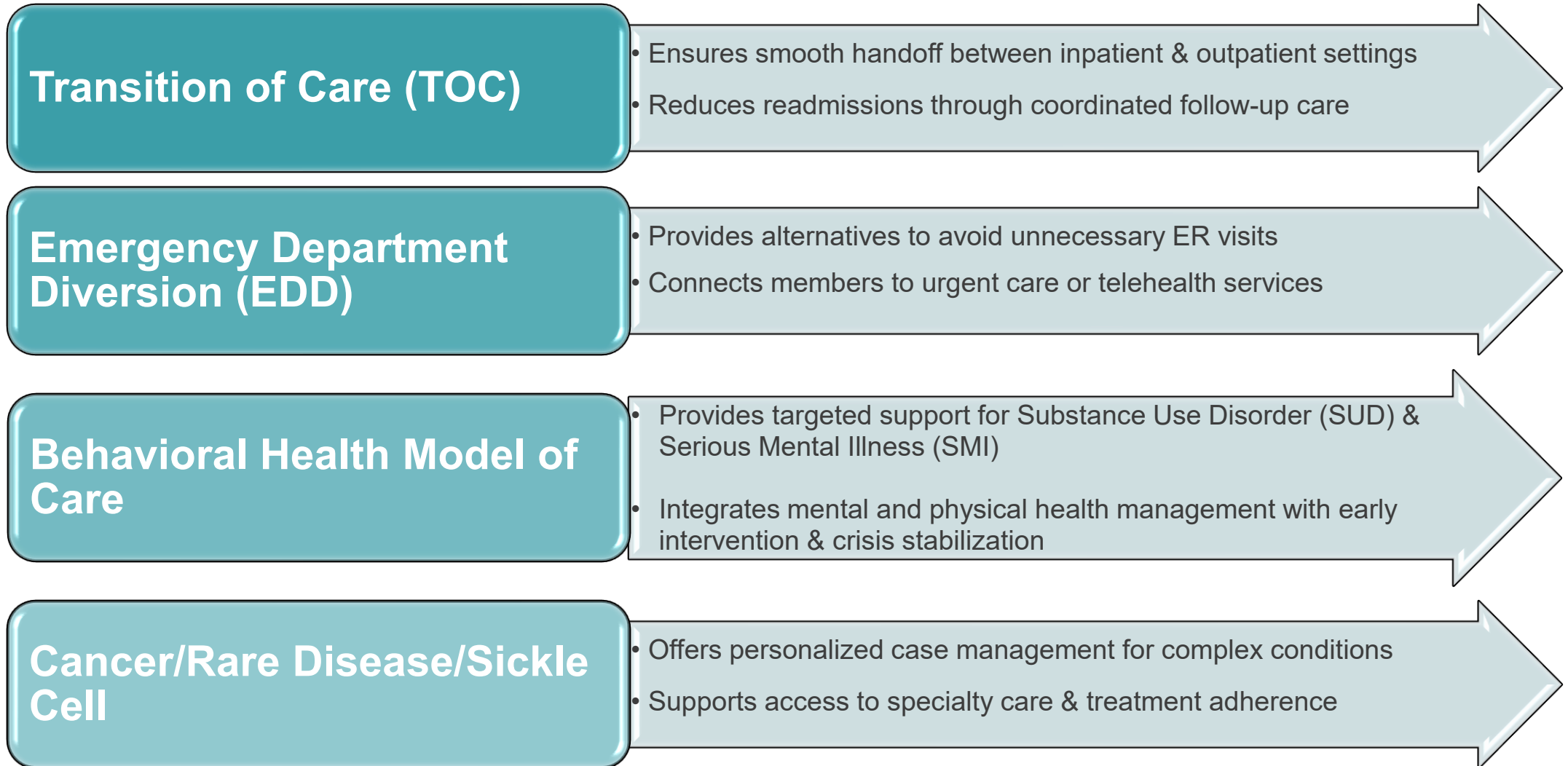
A dedicated team of Nurse Practitioners delivering in-home care to support Molina members with complex needs.

Key Program Features:

- **In-Home Preventive & Wellness Care**
Nurse Practitioners provide in-home visits for wellness exams, screenings, & preventive services.
- **Accurate Diagnosis & Care Gap Closure**
Ensure complete documentation of chronic conditions and help close HEDIS & quality measure gaps.
- **Point-of-Care Testing & Education**
Offer real-time testing & one-on-one education tailored to each member's health conditions.
- **Addressing Social Determinants of Health (SDOH)**
Identify housing, food, safety, & transportation needs through direct observation and engagement.
- **Member-Centered Coordination**
Act as a bridge between the member, their PCP, & Molina's CM team.
- **Care Extenders**
Serve as an added layer of support—expanding access, building trust, & helping reduce avoidable ED visits.



Case Management Programs



Contact Information & Referral Process



Referral Process for Care and Case Management Services

How to Make a Referral to Molina's Care/Case Management Team

Option 1: Call Us

Reach out to Member Services

Toll-Free: (844) 782-2018

TTY: 711

Ask to make a Care or Case Management Referral

Option 2: Email the CM Team

Send referrals to:

NE_CM@MolinaHealthcare.com

Include:

- ✓ Member Name & ID
- ✓ Reason for Referral
- ✓ Any Supporting Info (if available)

Pro Tip:

Anyone can refer — providers, staff, or even the member themselves!

When in doubt, refer it out!

Contact Information

Main Nebraska Office

- Address: 1471 W Center Road Suite 104, Omaha, NE 68144

Member One Stop Resource Center

- Address: 3301 Harney Street, Omaha, NE 68131

Member Services

- Phone: 1-844-782-2018 (TTY: 711)

BH Crisis Line

- Phone: 1-844-782-2721 (TTY: 711)

24 Hour Nurse Advice Line

- Phone: 1-844-782-2721 (TTY: 711)

Questions?



Thank You!

