MOLINA HEALTHCARE

Ohio MyCare Next Generation

Care Coordination & Population Health Program Overview

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March 2026

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Care Coordination & Population Health *The Leadership team, while providing direction and oversight of the staff and its efforts, also supports, fosters, and creates an ongoing dynamic culture of innovation and health care excellence through an integrated approach.*

Care Coordination Leads / Primary Points of Contact	CMO Dr. Tamara Thompson	Medical Advisement / Clinical Oversight
	VP Health Care Services Pam Tropiano	Healthcare Services Roadmap
	AVP Care Coordination Mary Smigle	Care Coordination Strategy
	Director Andrea Kadelak	Care Coordination / Care Transitions Daily Operations
	Director Caroline Hennessy	Long Term Services and Supports
	AAA Care Coordination Liaisons Kelly Schneider, Nicole Linkie, Kristin Huddle, Gina Garchar	Delegation Liaison Daily Operations
Population Health Leads	AVP Population Health Dana Ronnebaum	Population Health Management Strategy
	Manager Population Health Erica Booth	Population Health Daily Operations

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Care Coordination

- Our clinical programs reflect the guiding principles to optimize the health of the individual members and populations it serves while supporting and enhancing partnerships with community-based and delegated entities providing care and service coordination.
- Our dedicated care coordination and medical teams have focused their efforts on fully understanding the unique needs of the Ohio population.
- Our current membership continues to present with a variety of complex medical, behavioral health, psychosocial conditions, and long-term services and support needs. In addition, we have identified segments of our membership who have continued to present with high-risk needs and situations, resulting in the need to further develop targeted and focused clinical and psychosocial programs, including contracts with external entities, care coordination and care management entitles, providers, and subject matter experts to meet individual member needs.

We have developed a comprehensive Healthcare Services Program Description outlining our Care Coordination, Utilization Management, and Medicare Model of Care components. In addition, we have a stand-alone DSNP Model of Care and Population Health Program Description document.

We align to the Ohio Department of Medicaid Care Coordination contract requirements

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Care Coordination

- We incorporate Molina's Mission and Vision along with a wide variety of programs, solutions, and applications to ensure that our members can reach optimal health and wellness goals.
- The key evidence used to develop MHO's Care Coordination Program is based on the Case Management Society of America's Standards of Practice, the National Association of Social Work Case Management Guidelines, Ohio Department of Medicaid (ODM), CMS Duals Special Needs Plan Model of Care requirements, and NCQA requirements and standards.
- The Ohio care coordination teams utilize long-standing expertise within the MHO national center of excellence teams, specialized Behavioral Health Models of Care focused on Substance Use Disorder/Serious Mental Illness/Severe Emotional Disturbance, and other various Health service models, the National Practice Guidelines as approved by the MHO Medical Advisory and Medical Affairs group, data and analytics within the MHO Insights platform, and the practice guidelines and information used by the Care Advance clinical documentation system development team.
- The care coordination program incorporates the current NCQA Complex Case Management, Long term Services and Supports, Population Health Management standards and the ODM and Federal care coordination/case management guidance/guiding principles.

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Care Coordination – *Purpose and Scope*

Ohio Medicaid Next Generation Care Coordination Model

- The Next Generation Care Coordination program creates an opportunity for all members to receive person-centered care coordination support, without the need to qualify. The addition of the Care Guide role expands the opportunity for members to receive care coordination services at a level commensurate to the support they need.
- Care Management Overview
  - Care Coordination Vision and Goals:
  - To ensure safe, appropriate, and effective care.
  - To promote positive health outcomes.
  - To ensure patients receive care that is consistent with their goals.
  - To keep patients healthier, longer.
  - To prevent duplication of services, align care, and manage costs.
  - To advance health equity.
  - Identifying and addressing physical, behavioral, and psychosocial needs.
  - Supporting member goals and choices through a person-centered, trauma-informed, and culturally attuned approach.
  - Providing care continuity while honoring member experience and choice.

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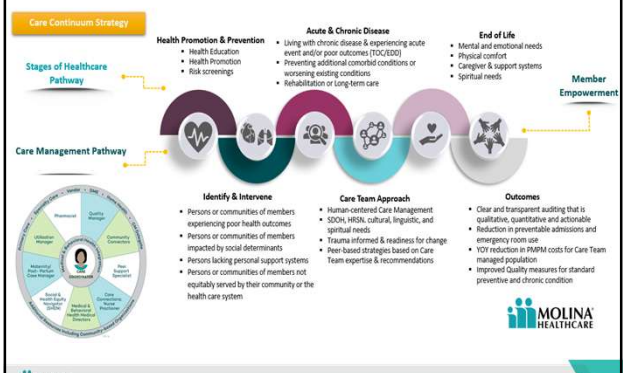
Care Coordination – *Care Continuum Strategy*



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Grand Rounds / Care Conference / Case Review Meetings

- We maintain an overarching Grand Rounds framework inclusive of but not limited to formal ICT meetings and Care Conference and Case Review meetings which are held each day as an integral part of MHO 's holistic and integrated approach to deliver care coordination / care management and UM services to those individuals with complex care and service needs.
- Reviews are focused on newly enrolled members or members transitioning on or off our programs, new facility member admissions or those members who experience a significant event, safety risk, potential quality of care variance, or a complex physical and / or behavioral health situation identified as requiring intensive review and follow up.
- While the complex members require an increased frequency of formal and ad hoc case reviews, the non-complex member case reviews and Care Coordination activities are carried out by the assigned care coordinator based on ongoing member needs.
- Care transitions of any type are reviewed and discussed ongoing between the Care Coordination and Utilization Management teams.

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Grand Rounds / Care Conference / Case Review Meetings

- ICT Meetings
- Care Conferences
- Case Reviews
- Clinical Consultations

- Evaluation Efforts Focused on:
  - ✓Maximizing expertise and communication across programs and departments
  - ✓Maximizing use of data and information received / shared
  - ✓Avoiding duplication of efforts
  - ✓Providing members needed care and services (basic and enhanced benefits when warranted)
- The Enhanced Grand Rounds Framework ensures that:
  - ✓Members being presented are formally reviewed and assessed for appropriate, person-centered, intervention and monitoring
  - ✓A streamlined process is in place to formally review, trend, and follow up on individual cases, including discharge planning and transitions of any type
  - ✓Promotion of a high quality and optimal health, safety, welfare for each member identified / reviewed
- The assigned Molina Healthcare Services lead obtains information and plans further outreach / interventions ongoing. Molina team members include, Utilization Management, Care Management, Pharmacy, Finance, Medical Staff, and Care Transitions / Connectors; external team members are invited as needed, including the Member
- The assigned Molina Healthcare Services lead identifies follow up action items, including outreach to community-based organizations, providers, the individual member / family / supports, and other key stakeholders as needed

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The Interdisciplinary / Trans-disciplinary Care Team

- The trans-disciplinary care team, led by the dedicated care coordinator/care manager, is supported by an internal multidisciplinary team including Medical Directors, Nurse Practitioners, Pharmacists, registered nurses, behavioral health professionals, maternity & postpartum professionals, LCSWs, utilization management specialists, community health workers, and peer support specialists.
- The dedicated care coordinator/care manager initiates collaboration with the member's entire trans-disciplinary care team, including primary and specialty care providers, care management and service coordination delegates, home health, durable medical equipment, vendors, community-based organizations, members, and others as designated by the member and their family/caregivers.
- The ICT helps to coordinate the care of members through a comprehensive, integrated, and individualized care planning process.

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The Interdisciplinary / Trans-disciplinary Care Team

- The comprehensive assessment has questions covering multiple domains to collect comprehensive information about the member's needs.
- Responses to questions on the comprehensive assessment may identify the need to include certain representatives in the ICT.
- For instance, if the member is on multiple medications, a pharmacist may be included; if the member has a behavioral health disorder, a BH professional may be included.
- The need to coordinate with Medicaid and include external agencies on the ICT may also be determined by reviewing the responses on the comprehensive assessment and collaborating directly with the member.
- The ICT may look different for each member based on their individual needs and the ICT will change as the member's condition or needs change which may result in adding additional members to the ICT team or removing existing members.

INTERNAL TRANS-DISCIPLINARY CARE TEAM PARTNERS

- Care Connections
- Utilization Management
- Maternal/Postpartum
- Pharmacy Services
- Medical Directors
- Quality Management

EXTERNAL TRANS-DISCIPLINARY CARE TEAM PARTNERS

- Inpatient & Outpatient Care Providers: (Primary Care, Behavioral Health, and Specialty Providers)
- Behavioral Health Care Coordination Entities
- Other Care Coordination Entities
- Care Management Delegates
- Service Coordination Delegates, including the AAAs
- Case Management/Social Worker partners
- Home Health
- Rehabilitation (ST/OT/PT)
- Vendor Partners
- Ancillary providers (DME, etc.)
- Community-based organizations
- Faith-based organizations

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Identifying At-Risk Members

- Our dual members are all assigned to a dedicated care coordinator / care manager, and identification and risk stratification are an integral part of the integrated care management process.
- The appropriate identification and risk stratification of the member are among the most important critical success factors in achieving optimal clinical outcomes.
- MHO's risk stratification and predictive modeling tools determine stratification levels for the various cohorts identified. The automated identification and stratification criteria identify members as follows:
  - Level 1/Low Risk
  - Level 2/Moderate Risk
  - Level 3/High Risk
  - Level 4/Intensive

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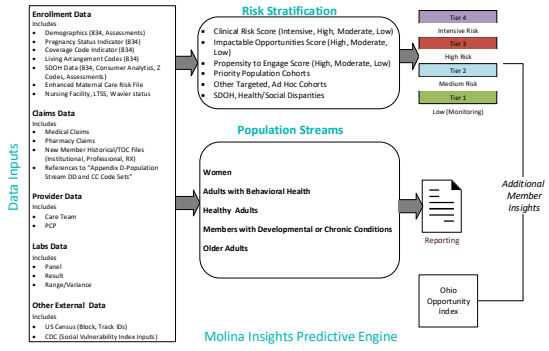
Molina Insights Predictive Engine



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Population Health and Care Coordination Framework Alignment

- We assign an initial risk stratification tier within the first month of a member's enrollment for newly enrolled members.
- We review and update the risk stratification tier following the completion of the member's comprehensive risk assessment and comprehensive assessment.
- We evaluates a member's risk stratification tier whenever there is a significant change in the member's needs or circumstances.
- Each risk stratification level or tier within the care coordination program and each team supporting the same is configured to have a caseload that meets the complexity of the stratification along with the complexity of the individual member.

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Care Coordination Contact Schedule

Risk Tier	Contact Schedule
Tier 1 — Low-monitoring	In-person visits determined by MCOP or per member request. Telephonic contact as needed.
Tier 2 — Medium	One in-person visit every six months. Maximum of 180 days between visits. Telephonic contact as needed.
Tier 3 — High	One in-person visit every three months. Maximum of 90 days between visits. Telephonic contact every 30 days.
Tier 4 — Intensive	One in-person visit every two months. Maximum of 60 days between visits. Telephonic contact every 30 days.

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Member's Chosen Primary Contact and Roles and Responsibilities

Care Coordinator (Molina)

- Serve as primary point of member contact.
- Lead completion of all assessments and development and approval of the person-centered care plan and waiver service plan.
- Lead care team collaboration, planning, and monitoring.

Waiver Service Coordinator (AAA)

- Serve as primary point of member contact.
- Lead completion of the comprehensive assessment and development and oversight of the waiver service plan.
- Participate in the care team and assist with monitoring member progress.
- The Molina Care Coordinator serves as secondary point of member contact, approves the waiver service plan, and leads care team collaboration, planning, and monitoring.

BH CCE Coordinator

- Serve as primary point of member contact.
- Lead completion of BH-related assessments and development of person-centered care plan.
- Participate in the care team and assist with monitoring member progress.
- The Molina Care Coordinator coordinates completion of other
- assessments, coordinates approval of the person-centered care plan and
- development and approval of the waiver service plan, and leads care
- team collaboration, planning, and monitoring

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Care Coordination Staffing & Delegation

Waiver Service Coordination vs. Care Coordination

Waiver Service Coordination

- Complete initial Waiver Services Assessment for members presenting a waiver need
- Complete annual reassessment based on the level of care for members receiving waiver services
- Develop, review and update the Waiver Service Plan which is integrated into the Person-Centered Care Plan
- Develop and document the Member's backup plan
- Coordinate approved waiver services, communicate with providers
- Collaborate with the Care Coordinator

Care Coordination

- Develop and maintain the Person-Centered Care Plan, integrate the Waiver Service Plan, collaborate with Waiver Service Coordinator to ensure contains all the Member's services and personal goals
- Assist with linkage to Molina providers
- Identifying and addressing gaps in care
- Transitions of Care
- Ensuring timely authorization and appropriate service delivery of services identified in the Person-Centered Care Plan
- Assess and Monitor identified health conditions
- Assessing and monitoring the Member's progress in achieving goals and outcomes
- Collaborate with the Waiver Service Coordinator

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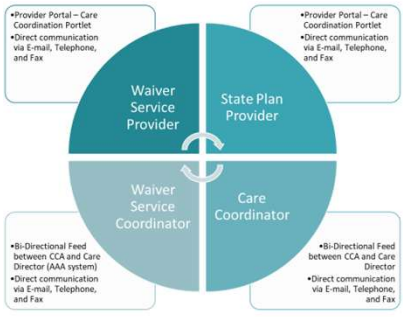
Care Coordination: Oversight Strategies



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Member Transition Processes – Primary Focus and Approach

Focus on Continuity of Care

- Dedicated team established focused solely on all aspects of the transition management process, including the assigned Transition Coordinator, assigned Care Manager, IT support staff, Area Agency on Aging (AAA), other delegates, and larger Interdisciplinary Care team (ICT)
- Primary goal of seamless transition management and close collaboration with external transitioning entities, i.e.; Home Care Waiver, OhioRISE, SRS, justice involved, other MCEs / MCOPs, etc.
- Transition Coordinators are assigned to specific entities and programs with designated points of contact – all ensuring seamless continuity of care, ensuring no interruption or delays in members receiving services
- Focus on including and preserving member's choice – building trusted relationships overall
- Comprehensive sharing of key member information via SFTP or Care Coordination Portal

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Transition of Care

The Transitions of Care model focuses on members experiencing ***transitions across care settings***. Each Dual member has a dedicated Care coordinator/care manager to support care coordination, care management, and navigation of the population health ecosystem. This includes intensive collaboration with the interdisciplinary care team for transitions between settings of care when a member:

- Has acute medical or behavioral health needs and has been admitted to a hospital and is being discharged to the community.
- Has been discharged from the hospital to an institutional setting including, but not limited to (Long-term acute care (LTAC), skilled nursing (SNF), nursing facility (NF), inpatient rehab (IRF), intermediate care (ICF), residential treatment (RTC))
- Has been discharged from an institutional setting to the community.
- Has been discharged from an institutional setting to a home and community-based setting.
- Has been admitted to an institutional setting from a home and community-based setting.

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Critical Incident Monitoring and Emergency Response Plans

Our critical incident monitoring system ensures member health, safety, and welfare.

Care Coordinators are trained on and coordinate end-to-end critical incident management including collaboration with providers and other entities to ensure appropriate member monitoring and follow-up.

We report critical incidents upon discovery, identification, or notification within one business day into Ohio's Incident Management System (IMS).

Upon completion of the investigation, the care coordinator will review the critical incident report for root causes and develop a prevention plan, as appropriate.

This plan is integrated into the members' care plan for ongoing monitoring and support and submitted to IMS within seven business days from date investigation is completed.

Through our Disaster/Emergency Response Plan, our care coordination team monitors and supports members during disasters and public emergencies through a prioritization system based on risks (e.g., ventilator use) to ensure continuous care.

We also develop individual-level emergency response plans, when appropriate, such as for members who are technology or service dependent, which is integrated into the members' care plan and shared through the Care Coordination Portal, so everyone involved in the member's care are aware of the response plan.

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Person-centered Care Planning

The Care coordinator/care manager will assess the needs of the member, identifying primary goals and interventions, dependent on the member's highest level of ability to change and will include from the member, their family, and the interdisciplinary care team (as determined by the member) focusing on managing member's care needs on a continuum ranging from self-management to crisis-management.

Care coordinator/care managers build an individualized person-centered care plan with all members and/or representatives.

The resulting ICP contains goals and interventions that also take into consideration the member's and/or representative's needs (which may include services), preferences and desired level of involvement.

The ICP is approved by the member and/or representative if they are engaged in the care planning process, reviewed by the ICT as applicable, then maintained and updated by the Care coordinator/care manager as the member's condition changes.

The Care coordinator/care manager schedules appropriate follow-up with the member and/or providers if members are not engaged in CM to assess progress and addresses barriers to meeting person-centered care plan goals.

The Care coordinator/care manager is also responsible for collaborating with providers to ensure the member is receiving the right care in a timely manner, consistent with the ICP.

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Population Health Management – *Cross System Collaboration & Coordination*

Care Coordination Portal

- We have established a Care Coordination Portal that collects, stores, integrates, shares, and pushes out pertinent member information with / to the entities involved in coordinating the member's care (ODM, CCEs, CMEs, and SPBM as applicable).
- Our Intake Support Team maintains primary responsibility of daily coordination of the portal data and dissemination of same.

MHO's Care Coordination Portal is available to members, ODM, the SPBM, CCEs, and / or CMEs, subject to access controls and requirements necessary to comply with state and federal privacy requirements.

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Population Health Management – *Cross System Collaboration & Coordination*

Care Coordination Portal

We provide timely electronic notification of sentinel events to all entities involved in the member's care coordination to support appropriate care coordination. Sentinel events, with expectations of required reporting timeframes, will be entered as follows:

- All cause (physical health and behavioral health) inpatient hospitalizations/re-hospitalizations will be entered on the same day as admission.
- ED visits will be entered upon notification to the MHO.
- Identified gaps in care will be entered within 72 hours of identification unless immediate action is necessary to ensure health or safety of the member.
- Residential treatment admissions will be entered within 72 hours of admission.
- Residential treatment discharges will be entered at least 72 hours prior to the planned discharge.
- Members with Mobile Response and Stabilization Services (MRSS) contact will be entered within 24 hours.

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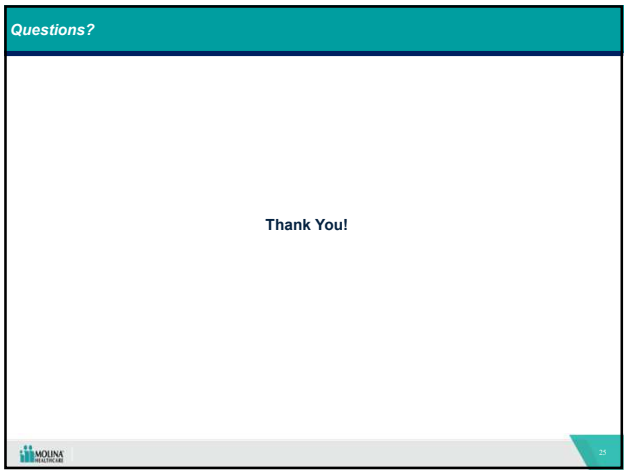

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