1. How are you executing contracts under your new FIDE-SNP product? If you are a provider that currently holds a contract under the MyCare product, will they automatically receive a new contract or an addendum? What about providers who do not have a contract? Are you open to contracting with all NFs statewide? What is the process for providers to be paid if they are not in network and a resident elects your plan

   Providers currently contracted under the MyCare product who have agreements encompassing both Medicaid and Medicare will not require a new contract or addendum. These existing contracts will remain valid for the FIDE-SNP transition, as they already include the necessary language to support dual-benefit coverage. However, if any changes arise as we approach January 1, 2026, implementation date, updates will be communicated promptly.

   We are open to contracting with Nursing Facilities (NFs) statewide. For providers who do not currently hold a contract and wish to become an in-network provider, the provider can reach out to the Provider Contracting team and/or submit a Contract Request form.

   All providers must be in network with ODM as an active provider. If a resident elects our plan and the provider is not in-network, payment processes will follow established protocols. Depending on the case-specific agreement with the provider at the time of the authorization review, a single case agreement may be required.

2. Can you first describe what training opportunities and resources you are making available for providers who have never contracted with your organization before?

   Molina offers a comprehensive suite of training and onboarding resources tailored to providers who are new to contracting with the organization. These resources are designed to ensure providers are well-supported from initial engagement through ongoing operations. If providers need assistance with the initial contracting process and are unable to locate the self-service tools, they may contact the contracting team for 1:1 assistance. Following an executed contract, the provider will receive a warm handoff to the Provider Relations team for comprehensive onboarding. Through our *You Matter to Molina* program, we have robust resources for a quick start to doing business with Molina, along with monthly live training opportunities, and always ad hoc 1:1 meetings as needed.

3. Can you talk about what changes are being made, internally, to support a statewide implementation of your plan. For example, in the first phase with 20 counties, will you have case managers ready for the new buildings on day one?

Molina will have our care coordinators ready for the new buildings on day one. The MyCare Nursing Facility Care Management Team is currently doing preparatory work for this.

4. How will your UM and case management practices differ with respect to the beneficiaries enrolled in your plan for Medicaid only versus both benefits?

   In Care Management, Molina is strengthening the focus on continuity of care and all the transition pieces to ensure that the members' needs are met, regardless of if they are enrolled in Molina for Medicaid only vs both benefits. Our Transition Coordinators will track members moving between settings and plans, and help to triage and connect Care Coordinators to the member's Medicare payors, external agencies, etc. Readiness training is in place focused on the comprehensive dual benefit structure. Collaboration between the assigned primary care coordinator and the UM team is ongoing.

5. Drilling down a little more on that, will a PA be required for NFs admissions under Medicaid? Will PA be required for NF admissions under Medicare? What about moving from Medicare to Medicaid as a payor, how will that be handled within a NF? Specifically, how will authorizations be obtained (what to send and where?) and what are your timeframes for admission authorizations?

   No PA is required for Medicaid, long term care benefit.

   No changes in the PA process for skilled Medicare stays. PASSAR requirements remain the same.

   When a member moves from skilled to non-skilled level of care, there is communication and collaboration between the facility and Molina teams (UM and Care Coordination). The Molina Care Coordinator validates the PASSAR and completes the level of care assessment. The assigned Care Coordinator engages with all stakeholders and members/family for all transitions.

6. Will you allow "skilling in place" for dual-benefit beneficiaries to access their Medicare benefits without needing a 3-day hospital stay? Operationally, how would the facilities request this?

   Molina waives the 3-day hospital stay requirement and allows skilling in place.

   No need to request.

7. Will there be a dedicated case manager assigned to each facility or each beneficiary? How would a facility identify that individual?

   There will be a dedicated Care Coordinator for each facility, and that care coordinator will be assigned to all Molina MyCare members in that facility. The Care Coordinator will spend time with facility staff in the months to come, providing contact information and ensuring the facility knows how to reach them.

8. How will you coordinate authorizations for implementation periods for all residents in a building, especially if you use multiple case managers for one facility?

   The Molina Transition Coordinator role is responsible for all continuity of care information (reports), authorizations, etc. The transition Coordinator works closely with the assigned care coordinator to ensure continuity of care.

9. Can you elaborate on the role of case managers in your organization with respect to services provided within a NF setting.

   The Care Coordinator conducts member assessments, leads the development of the person-centered care plan, identifies and links to Molina in-network providers, coordinates access to covered services as needed, educates the member about available resources and services, facilitates transitions of care, participates in discharge planning activities, to name a few of the primary responsibilities. In the NF setting the Care Coordinator closely collaborates with NF staff when completing these activities and includes the NF staff as part of the member's Interdisciplinary Care Team while working towards the member's identified goals.

10. Are there any assessment requirements required under this program whereby the facility can expect a visit from a case manager periodically?

    The Molina Care Coordinator will complete an annual assessment in person with the member. Face-to-Face visits will occur at a minimum of 2 times per year, more depending on the member's identified risk tier. This document currently on our website will continue to be relevant in 2026: https://www.molinahealthcare.com/providers/oh/duals/~/media/Molina/PublicWebsite/PDF/providers/oh/Duals/nursing-facility-care-coordination-visit-guide.pdf

11. How do you assist a facility in coordinating specialty physician services or other outpatient services that one of your beneficiaries residing in a NF may need? Who shall

the NF call to assist if they cannot find one of these specialty services (dental as an example) or we are unaware if a certain provider is in network?

The Care Coordinator can assist with identifying and linking to services and providers.

12. How do you handle medical transportation? Do you use a broker, or do you allow the facility to arrange transports directly with in-network medical transportation companies?

    We do use Access2Care, but facilities may also arrange transport directly with an in-network medical transportation provider. The Care Coordinator can assist with any member's specific transportation needs.

13. How do you assist a facility with discharging an individual who no longer meets medical necessity yet has unstable or unreliable housing?

    The Care Coordinator will collaborate with the facility to work towards an appropriate discharge plan. The Care Coordinator will complete referrals as appropriate to community resources and engage the Molina Housing Specialist as needed. The Molina NF Care Coordinator will complete a warm hand-off to the Molina Community Care Coordinator upon discharge to ensure work continues to maintain housing. A formal interdisciplinary care team meeting will be held to review the planning of a safe discharge to the community or elsewhere.

14. Are there any value-added services that you believe would be beneficial to your long-stay Medicaid beneficiaries living in a NF?

    There are a variety of value-added benefits and services for all members. We will be offering a package called Caregiver Connect with a host of extra benefits, including additional trips for caregivers to visit their loved one in a SNF. Another benefit will be helping with moving expenses when a member needs to relocate to a SNF. This can be an unnecessary burden on the family. We want the transition to be as smooth as possible.

    All members have access to specialized partnerships, for example, Accordant Care Rare, Pure Healthcare, Cityblock, and HealthMap. All members have access to our 24/7 Nurse advice line and behavioral health crisis line.

    All members have access to transportation benefits.

Our skilled Care Coordinators are always available to help members access the services and supports they need.

For opt in dual benefit members, these members will receive:

a. Advice from nurses by phone via the 24-Hour Nurse Advice Line.
b. Digital handheld language translator, for members with Limited English Proficiency.
c. Financial assistance for legal services, for members who want to file a petition for guardianship or need help with asset protection & financial planning to protect and maintain their home.
d. Financial assistance, for members transitioning to a community setting – including transitions from a NF or transitions from a caregiver's home to their own home.
e. Social Connections Program, where members can request a call from a compassionate call center to check in, if the member is feeling lonely or in need of SDOH supports. Members who qualify can also get a smartphone and phone plan and help from Technology Coaches to access services by computer or phone.
f. Monthly prepaid card, for OTC medicines or supplies. (Members who qualify for SSBCI can also use those funds monthly for transportation, healthy food, utilities, and rent assistance for Assisted/Senior Living Facilities.)
g. 104 one-way trips to healthcare visits, pharmacies, SSI or CDJFS Redetermination visits, WIC, grocery stores, food banks, health ed visits, and employment support.

15. Many of our SNF providers also have assisted living waiver associated with their facilities. Currently, the option to delegate waiver service plan assignment to the PAA varies by plan. Can you clarify what your plan is doing for waiver service plan delegation? In other words, will the AAA do that, or will your utilization management team?

If over the age of 60, the member can choose their Waiver Service Coordinator; for Molina it can be the AAA or a Molina Care Coordinator based on member choice.

If under the age of 60, the Molina Care Coordinator is assigned.