QUALITY INSIDER PROVIDER NEWSLETTER

2026

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Chief Medical Officer

The 2026 issue of the Molina of Massachusetts (Molina) Annual Quality Insider newsletter contains valuable information and resources on a variety of quality improvement topics. We look forward to another year of successful partnership aimed at improving outcomes for your Molina patients.

For the Star 2027 cycle (measurement year 2025), Molina of Massachusetts earned a 4.5 star rating from the Centers for Medicare and Medicaid Services (CMS) Star Rating Program. This industry-wide rating system from CMS compares quality performance among Medicare Advantage (MA) plans by collecting and measuring data from multiple sources to inform the star rating. The public can compare the star ratings of health plans on the CMS website when choosing a high quality MA plan. This achievement could not have been accomplished without the partnership and engagement of our network providers. We thank you for your help with quality improvement efforts aimed at improving outcomes for our members! We hope you find this publication to be a valuable tool for your practices.

Substance use disorder treatment

The American Psychiatric Association (APA) defines substance use disorder (SUD) as: "a complex condition in which there is uncontrolled use of a substance despite harmful consequences. People with SUD have an intense focus—sometimes called an addiction—on using a certain substance(s) such as **alcohol**, tobacco, or other psychoactive substances, to the point where their ability to function in day-to-day life becomes impaired. People keep using the substance even when they know it is causing or will cause problems."[1]

The statistics are alarming.

- Drug overdoses have killed over 1 million people in the United States since 1999.
- $11 billion in health care costs were related to the use of illegal drugs and $161 billion for prescription opioids.
- 2.6% of adults in the US had a co-occurring serious mental illness (SMI) and SUD in 2023.
- Nearly 45% of people with SUD also have mental illness.[2]

Molina Healthcare offers resources for providers to identify and provide care to members with SUD. In 2023, the Commonwealth of Massachusetts implemented the Massachusetts Roadmap for Behavioral Health Reform (The RoadMap) to improve access to mental health and substance use disorder treatment. Crisis services are available to anyone in the state. For more information about Molina Behavioral Health programs and available resources, visit our provider website here: **MolinaHealthcare.com/providers/ma/swh/resources/Behavioral-Health.aspx**

Follow-up after a behavioral health inpatient admission

Continuity of care following a hospitalization for behavioral health conditions is an important component of effective discharge planning. Close follow-up after discharge helps decrease potential for relapse and improves outcomes following psychiatric treatment. According to a study by Smith et al, 30% to 50% of patients discharged from an inpatient psychiatric hospital do not attend post-discharge appointments within 30 days, resulting in adverse outcomes[3]. The importance of primary care providers in the discharge process is vital to improve safety in the community and prevent relapse and readmission.

Strategies to ensure a safe discharge for patients with psychiatric disorders include:

- Collaboration with the inpatient team during the hospital stay and at discharge to review medication changes and treatment recommendations upon discharge
- Outreach after the patient is discharged to provide education and support, and to ensure the patient attends their follow-up appointment
- Building time into the office schedule for follow-up visits for patients getting ready for discharge
- Strong communication with Molina care managers to ensure patient is safe at home
- Share information and resources with patients after discharge for crisis intervention if needed. Information on resources:
  - Call 911 or go to the nearest ER for any behavioral health crisis
  - Suicide and Crisis Lifeline – CALL 988. For TTY, dial 711.
  - Community Behavioral Health Center Adult Mobile Crisis Intervention at (877) 382-1609. For TTY, dial 711.
- Massachusetts Behavioral Health Help Line **www.masshelpline.com**; call or text (833) 773-2445. For TTY, dial 711.

[1] Tourise, B. (2024, April). What is a Substance Use Disorder? American Psychiatric Association. **https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder**

[2] National Center for Drug Abuse Statistics. (2025). Drug Abuse Statistics. **https://drugabusestatistics.org/**

[3] Smith TE, Haselden M, Corbeil T, Tang F, Radigan M, Essock SM, Wall MM, Dixon LB, Wang R, Frimpong E, Lamberti S, Schneider M, Olfson M. (2020, January) Relationship Between Continuity of Care and Discharge Planning After Hospital Psychiatric Admission. Psychiatr Serv. https://pmc.ncbi.nlm.nih.gov/articles/PMC7008713/

The Medicare Annual Wellness Visit (AWV)

Medicare provides for an Annual Wellness Visit (AWV) for eligible patients, covered 100% by Medicare. The AWV is separate from the annual physical. The AWV appointment allows valuable time for the provider and patient to discuss wellness, prevention and health goals. A written plan is developed for patients to take with them to help optimize health. Medicare pays for the cost for these visits.

The visits address prevention and wellness and provide patients with a written plan to optimize health and prevent disease and disability. The components of Medicare AWVs include:

- Initial Preventive Physical Exam (PPE) – "Welcome to Medicare" visit – one-time visit per lifetime if the visit occurs within the first 12 months after Part B coverage starts
- Initial Annual Wellness Visit – development of a health risk assessment (HRA) and preventive care plan
- Subsequent annual visits – covered once per year for updating the HRA and care plan based on patient status

There is an optional covered component where providers can discuss advance care planning (ACP) with members if the ACP discussion is billed at the same time as the AWV.

Members who complete their AWV can earn dollar rewards that get added to their Nations benefit card through the Molina Healthy Actions Rewards Program. Please remind members of this program when scheduling their AWV. Members can call the Wellness Team at (855) 483-8740 (TTY: 711), Monday - Friday, 8 a.m. to 5 p.m. local time for more information. You can find more details on the program here: **MolinaHealthcare.com/members/ma/en-us/mem/Medicare/Healthy-Actions-Rewards-Program.aspx**

Once a member completes their AWV with their provider, details of the visit should be documented accurately and completely, including all chronic and acute conditions addressed. Accuracy in documentation is vital for our providers to get full credit for the care provided, and to ensure patients are in the appropriate health risk categories. Patients should leave the visit with a written plan including a list of screenings and vaccinations needed, treatments or treatment options and resources.

Appropriate ICD-10 codes should be submitted to represent all acute and chronic conditions.

The HCPCS codes for accurate documentation of the actual AWV include:

- G0402 – Initial Preventive Physical Exam (IPPE)
- G0438 – Initial AWV
- G0439 – Subsequent AWVs
- G0468 – Federally Qualified Health Center (FQHC) Visit
- 99497 – Advanced Care Planning – first 30 minutes – optional ***during*** *AWV*
- 99498 – Advanced Care Planning – additional 30 minutes – optional ***during*** *AWV*

Find more detailed information about the Medicare Annual Wellness Visit here:
cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits

Colorectal cancer screening

According to the U.S Preventive Services Task Force (USPSTF), colorectal cancer is the third leading cause of cancer death for both men and women. In 2018, 31.2% of eligible adults were not up to date with their screening[4] . Please join in our efforts to reduce risk of developing the disease through routine screening. Recommendations for screening intervals and accurate billing codes are in the table below:

Colorectal cancer screening type:	Recommended screening intervals:	HEDIS® billing codes
High-sensitivity gFOBT or FIT	every year	CPT: 822470, 82274 HCPCS: G0328
sDNA-FIT	every 1 to 3 years	CPT: 81528
CT colonography	every 5 years	CPT: 74261-74263
Flexible sigmoidoscopy	every 5 years	CPT: 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350,
Colonoscopy screening	every 10 years	CPT: 44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398 HCPCS: G0105, G0121
Flexible sigmoidoscopy	every 10 years + FIT every year	See codes above

The following situations exclude patients from the measure denominator:

Exclusions from the measure:	
Persons with a date of death in the measurement period	Medicare enrollees, 66 years of age and older by the last day of measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI)
Persons in hospice or using hospice services	Person 66 years of age or older by last day of measurement period, with both frailty and advanced illness
Persons receiving palliative care	History of colorectal cancer and/or total colectomy

[4] U.S. Preventive Services Task Force. (2021). Colorectal Cancer: Screening. U.S. Department of Health and Human Services. **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening**

Molina Healthcare actively engages eligible members in colorectal cancer screening through a variety of interventions. Activities currently in place include:

- Gaps in care lists are made available to providers.
- Local HEDIS® team interrogates data and outreaches providers and nurse care managers with actionable interventions to close care gaps.
- Let's Get Checked (LGC) sends fecal immunochemical test (FIT) kits to members due for screening. A multi-pronged workflow is in place for getting kits completed and sent back to the lab.
- Call and text campaigns are in place for eligible members due for colorectal cancer screening.
- Cityblock Health clinicians work with members through targeted outreach to assist with completing home test kits.
- A member incentive program rewards eligible members who complete colorectal cancer screening and submit an attestation. Please promote this incentive program to Molina members! You can find details on the program here: **MolinaHealthcare.com/members/ma/en-us/mem/Medicare/Healthy-Actions-Rewards-Program.aspx**

Breast cancer screening

In 2024 the U.S. Preventive Services Task Force (USPSTF) updated recommendations for breast cancer screening to be done biennially in women age 40 through 74. [5] Early detection is key for successful treatment if a diagnosis of breast cancer is indicated. Efforts are underway to get eligible members in for mammograms.

Strong performance on Healthcare Effectiveness Data and Information Sets (HEDIS®) for the breast cancer screening (BCS) measure demonstrates high quality care and contributes to Molina's star rating from CMS. Local interventions to improve rates of breast cancer screening include call and secure text messaging campaigns to eligible members, meetings with targeted providers to share gap list data and resources for closing gaps, member education through our clinical team and member newsletter articles, and the Healthy Actions member incentive program rewarding members for getting a mammogram. HEDIS® codes used for the BCS measure include, but may not be limited to, the following:

Description	Code
Mammography	CPT: 77061-77063; 77065-77067

Measure exclusions include:

Description	Code
Absence of Left Breast	ICD-10: Z90.12
Absence of Right Breast	ICD-10:Z90.11
Bilateral Mastectomy	ICD-10: OHTV0ZZ
History of Bilateral Mastectomy	ICD-10: Z90.13
Unilateral Mastectomy	CPT: 19180, 19200, 19220, 19240, 19303-19307
Unilateral Mastectomy Left	ICD-10: OHTU0ZZ
Unilateral Mastectomy Right	ICD-10: OHTT0ZZ

Suggested strategies to increase rates of breast cancer screening include:

- Implement standing mammogram orders and outreach patients within the appropriate age range coming due for screening.
- Provide routine education on the importance of screening and early detection, and offer educational materials in the members' language when possible during routine visits.
- Provide resources and reassurance for patients anxious about undergoing mammography
- Employ cultural humility practices and motivational interviewing techniques when working with patients who may have hesitancy due to cultural beliefs.
- Share results with your patients in a timely manner to alleviate anxiety and build trust.

You can find information and trainings on Culturally and Linguistically Appropriate Resources by signing into the provider portal here: **Availity.com/molinahealthcare/**

[5] BCS: U.S. Preventive Services Task Force. Nicholson, W.K., M. Silverstein, J.B. Wong, M.J. Barry, D. Chelmow, T. Rucker Coker, et al. June 11, 2024. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." JAMA 331, no. 22: 1918. **https://doi.org/10.1001/jama.2024.5534**

Supplemental data source (SDS) connections and quality improvement

Partnering with providers to establish supplemental data source (SDS) connections is a vital component of Molina Healthcare's Quality program strategy. The National Committee on Quality Assurance (NCQA), an independent organization contracted by government agencies to oversee quality in health care, developed and owns the HEDIS® measure system. HEDIS® performance makes up a significant portion of the data that informs the CMS Star ratings for Medicare Advantage plans. The NCQA is transitioning away from traditional Hybrid reporting, and HEDIS® measures are being moved to the Electronic Clinical Data Systems (ECDS) Methodology.

Hybrid HEDIS® measures that relied on medical record review and chart chasing are being phased out. This shift means only claims or encounter data will be used going forward, which may cause performance rates to decline. However, there is good news - supplemental data gathered through established SDS connections can be leveraged to help minimize the impact and strengthen rates. By establishing SDS connections, data that is historically challenging to access can be used to document and get credit for the care you are already providing.

Some examples include:

- Lab vendor data
- State immunization registries
- Data reported by members
- Provider portal data found in documentation
- EHR systems

SDS connections lead to significant reduction in time spent on chart chases and responding to data requests. And with the upcoming changes from NCQA, SDS connections are in focus throughout the industry. Learn more about ECDS and what steps NCQA is taking as part of this transition: **ncqa.org/resources/hedis-electronic-clinical-data-systems-ecds-reporting/**

Please contact Michele Richard for information on establishing SDS connections with Molina Healthcare at **Michele.Richard@MolinaHelathcare.com**

Electronic health records access

Molina partners with providers to share data through electronic medical record (EMR) connections. Sharing access helps to streamline data collection for risk adjustment data validation (RADV) audits, HEDIS® reporting, chronic care condition validation and other quality improvement initiatives.

Benefits of sharing EMR include:

- Reduces time spent responding to data requests through traditional chart chases
- Supports compliance in accurate documentation/coding
- Improves coordination of care
- Supports delivery of high-quality, efficient value-based care

Please contact Michele Richard at **Michele.Richard@MolinaHealthcare.com** for more information

Clinical practice guidelines and preventive health guidelines

Incorporating evidence-based practice guidelines into your care of our members helps ensure your patients receive the most current recommended practices in the management of their health. Molina Healthcare offers a comprehensive library of clinical practice and preventive health guidelines to our network providers. Guidelines are monitored and updated each quarter by Molina Healthcare before review and approval by the Molina Medical Advisory Committee for Massachusetts. Changes and updates are posted to our website on a quarterly basis for your convenience.

You can view the recently updated clinical practice and preventive health guidelines on our website under the Health Resources tab by going here: **MolinaHealthcare.com/providers/ma/swh/home.aspx**

Chronic conditions and burden of illness - documentation

Accurate documentation and coding to the highest level of specificity is vital to ensure the health needs of your patients are fully captured in the medical record. Chronic condition documentation helps establish a baseline of your patients' health status and can help predict potential future health needs.

For each chronic condition that is addressed during a patient encounter, accurate documentation should include specific diagnoses, current status, and treatment plan for each condition. These efforts also support quality improvement efforts on an ongoing basis.

Documenting at the highest level of specificity to capture a patient's full burden of illness goes a step further. This involves documentation of chronic conditions as well as acute conditions and manifestations, current health status, complications, and detailed treatment plan. Using this comprehensive approach to documenting accurately produces multiple benefits, including:

- Patients with higher medical complexity receive the appropriate risk rating to determine allocation of resources.
- Patients are able to receive the right care and support they need for both chronic and acute conditions over time.
- Patients with higher levels of medical complexity receive the appropriate time needed during appointments.
- Health outcomes are improved for patients when conditions are documented and therefore addressed during health care visits.

When chronic conditions and full burden of illness are not accurately documented in the patient record, it can lead to missed opportunities:

- Overlooked exams, diagnostics or screenings
- Missed medication or quality reviews
- Missed referrals or follow-up that may be needed
- Incomplete coordination of care across settings

Accurate and specific documentation in the medical record is a key component of quality improvement efforts at Molina. The information informs predictions of future health care needs and costs of care, improving our ability to ensure that patients get the appropriate health related treatments and care they need.

Molina offers network providers tips and coding resources for accurate documentation of chronic conditions to support your practice.

Controlling blood pressure among patients with hypertension

CMS assigns a heavy weight for the Controlled Blood Pressure (CBP) HEDIS® measure. Hypertension is a top chronic condition among our members and supporting patients with hypertension to help manage and control blood pressure (BP) is a high priority. Multiple interventions are in place to improve the rates of blood pressure control among eligible members.

Molina intervention:	Description:
Hypertension Disease Management program	Dedicated RN coaches work closely with members enrolled in the program until they meet graduation criteria
Provider Engagement Team	Sharing gap lists with targeted provider groups to improve rates of controlled blood pressure among Molina members
HEDIS® Clinical Team	Health care Services team closing HEDIS® gaps through a wide variety of high quality and detail-oriented interventions
BP Cuff program	Eligible members are ordered for a home BP cuff through their nurse care manager or their Molina pharmacist
Care Connections annual preventive visits (APVs)	Include BP checks, reporting results, and referrals of eligible patients to disease management program
Cityblock Health	Visits to eligible members with hypertension that include BP checks and follow-up, including referrals to disease management
Champions Program	Text campaign where eligible members consent to receive education on controlling BP
Call Campaign	Eligible members receive scripted calls to connect them to preventive services that support BP control
Member Education	Member education flyers in multiple languages to help members; pertinent articles in member newsletters
Healthy Actions Member Rewards Program	Members receive an incentive for completing specific health screenings. Rewards earned are added to their Healthy You OTC card to purchase healthy foods.

Tips for providers to support these efforts:

- Utilize Culturally and Linguistically Appropriate Standards (CLAS) to educate and promote medication adherence.
- Schedule routine BP checks for patients with uncontrolled BP, using Telehealth when necessary.
- Share educational materials as needed, preferably in the patient's language where possible.
- Assess/reassess member education needs, reinforcing how to take a BP at home.
- Use available resources to share information with patients using teach-back to confirm their understanding. Find more information here: millionhearts.**hhs.gov/tools-protocols/tools.html**
- Refer patients with uncontrolled BP to Molina Hypertension Disease Management.
- Communicate medication adherence concerns to pharmacist and nurse care manager.

Please contact your network manager or provider engagement specialist for tip sheets with accurate HEDIS® coding for the CBP measure if needed.

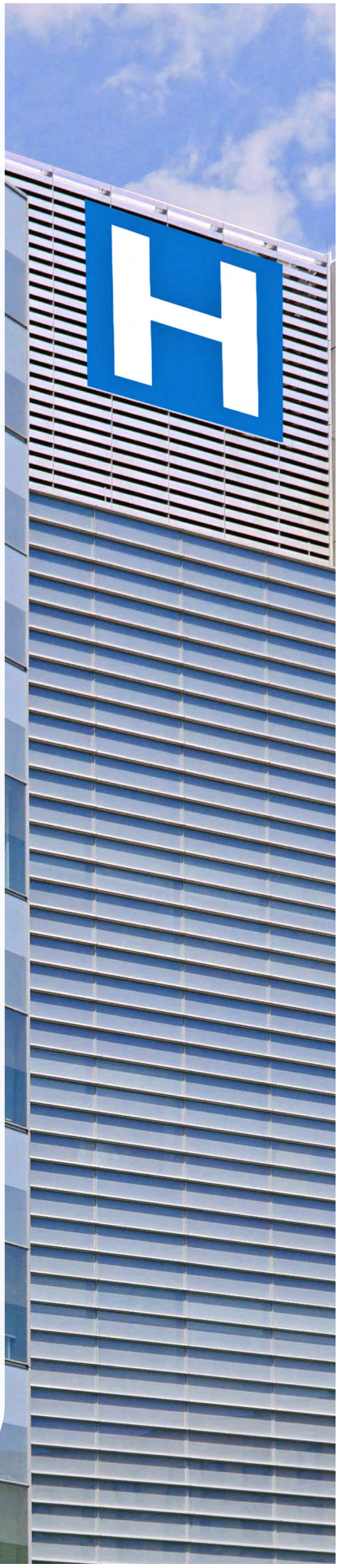
Reducing hospital readmission rates

Avoidable hospital readmission rates are an important indicator of health care quality. Reducing readmissions is a vital component of Molina's Quality strategy to ensure a safe discharge and improve outcomes for members. For HEDIS® performance purposes, reducing rates of readmissions is a high priority. Molina is addressing this topic through a variety of quality improvement efforts and member outreach. Please support our efforts by engaging members leaving the hospital using a comprehensive outreach strategy.

Provider tips to reduce hospital readmissions:

- Check in with the inpatient team for progress updates when you learn your patient was admitted to the hospital
- Conduct post-discharge calls within 3 days of discharge to assess the patient's needs and ensure a follow-up appointment is scheduled
- Have office staff assist with transportation coordination if needed for members needing help to get to follow-up appointments
- Reconcile medications with member/caregiver to confirm current post-hospital medications and assess understanding of use, dosage and administration.
- Communicate with patient's pharmacist to ensure post-discharge medication reconciliation is conducted
- Reinforce discharge instructions and educate members on condition-specific instructions and materials, including red flag symptoms. Use teach-back method to ensure understanding.
- Notify all involved providers (specialists, behavioral health providers) of member's discharge and share updated records if needed.

The Guide for Reducing Disparities in Readmissions from the CMS Office of Minority Health contains valuable data and information for providers to assist in reducing avoidable readmission among patients with health inequities. Learn more here: **www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf**



Osteoporosis management in women who had a fracture

CMS assigns a heavy weight for the Controlled Blood Pressure (CBP) HEDIS® measure. The prevalence of osteoporosis goes up in women age 65 years and older, and among Asian, Hispanic and White persons.[6] Swift evaluation and management of osteoporosis for women who suffer a fracture is vital to Molina quality improvement efforts given this is a time-sensitive HEDIS® measure. Women must have a bone marrow density (BMD) test within 180 days of their fracture, or they must have an eligible prescription filled within 180 days of the date of their fracture to comply with the measure. Medications that meet the criteria for osteoporosis treatment to satisfy HEDIS® requirements include:

Bisphosphonates: Alendronate; Alendronatecholecalciferol; Ibandronate; Risedronate; Zoledronic acid

Others: Abaloparatide; Denosumab; Raloxifene; Romosozumab; Teriparatide

Use the following when coding for OMW:

Description	Code
Bone mineral density test	CPT: 76977, 77078, 77080 77081, 77085, 77086 ICT-10: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
Osteoporosis medication therapy	HCPCA: J0897, J1740, J3110, J3111, J3489
Long-acting osteoporosis medications (for inpatient stays only)	HCPCA: J0897, J1740, J3489

[6] US Preventive Services Task Force. Nicholson, W.K., Silverstein, M., Wong, J.B., Chelmow, D., T. Rucker Coker, et al. January 14, 2025. "Screening for Osteoporosis to Prevent Fractures – US Preventive Services Task Force Recommendation Statement". **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening**

Vaccination and motivation for patients hesitant to accept vaccines

Vaccinations are vital to maintain wellness and reduce risk of disease and disability, especially among older adults and individuals with chronic medical conditions. Molina encourages providers to discuss the importance of vaccination with all patients. Having targeted conversations with patients showing vaccine hesitancy is important. Some examples of why patients may decline to get vaccinated include:

- Fear or distrust
- Socioeconomic factors – access, transportation
- Cultural beliefs
- Personal beliefs and health preferences
- Complacency
- Misinformation

It is important that education provided considers patient beliefs and reasons for avoiding vaccination. For culturally diverse patients showing hesitancy, using materials in the patient's language and understanding the reasons behind their hesitancy can help overcome barriers to change. Motivational interviewing (MI) techniques are often used to help effect change in patients who may be reluctant to accept a vaccine. MI is a style of communicating that helps patients change behaviors through empathy, listening, and understanding the reasons behind reluctance.

We appreciate the efforts encouraging our members to get vaccinated. We encourage providers in our network to consider MI training to incorporate into your practice. You can learn more about MI here: **motivationalinterviewing.org/**

You can find the current CDC recommended vaccination schedule for adults here: **cdc.gov/vaccines/imz-schedules/adult-easyread.html**

Improving HbA1c results in diabetic patients

The 2026 National Diabetes Statistics Report from the CDC notes that 115.2 million adults aged 18 and older in the United States have prediabetes, and 28.8 million adults have been diagnosed with diabetes. Incidence of diabetes diagnoses is highest among American Indian or Alaska Native, Black, Hispanic and Asian individuals. The prevalence of diabetes has increased significantly among U.S. adults aged 18 or older between 2001 to 2023.

Diabetes is the leading cause of end-stage kidney disease among 39.2% of adults in the U.S. It is also the leading cause of blindness or severe vision difficulty among U.S. adults aged 18 or older.[7]

Diabetes is one of the top three chronic condition diagnoses among Molina of Massachusetts members. Interventions across multiple areas are in place to improve rates of HbA1c and prevent potential complications such as visual changes or kidney failure. Through our disease management (DM) program, eligible members receive multi-disciplinary care through close monitoring, coaching and ongoing education to help control diabetes. Molina also offers programs such as call and text campaigns, outreach by Cityblock and Care Connections aimed at completing diabetes screening tests, and member education through newsletter articles, social media posts, Member Advisory Council meetings and collaboration through provider engagement efforts.

Encouraging your Molina patients with diabetes to complete their annul screenings and maintain stable glucose levels demonstrates your commitment to patient care and quality improvement. Other tips include:

- Utilize standing orders for HbA1c testing and conduct testing 2 – 4 times per year.
- Remember the last HbA1c level of the year is used for HEDIS® reporting.
- Adjust therapies to improve HbA1c levels.
- Flag patients in your system who need follow-up diabetes monitoring and conduct outreach.
- Prescribe statin therapy to patients with diabetes age 40 to 75 years

You can find helpful patient education resources from the CDC here: **cdc.gov/diabetes/treatment/your-diabetes-care-schedule.html**

[7] Centers for Disease Control and Prevention. (2026) National Diabetes Statistics Report, March 11, 2026. **https://usdss.cdc.gov/diabetes/report.html**

Reminders to share with Molina Members:

Healthy Actions Rewards Program for Molina Members:

Please take the opportunity during routine appointments to remind Molina members of the Healthy Actions Rewards Program. Your patients can earn rewards for completing certain health screenings. Rewards are added to their over-the-counter (OTC) card that can be used to purchase healthy foods. Use these links to find more information on the program for both SCO and One Care members:

MolinaHealthcare.com/members/ma/en-us/mem/Medicare/Healthy-Actions-Rewards-Program.aspx

MolinaHealthcare.com/members/ma/en-us/mem/Medicare/onecare/Healthy-Actions-Rewards-Program.aspx

Molina of Massachusetts Member Advisory Committees

The Quality team at Molina hosts a Member Advisory Committee for our SCO and for our One Care members. Meetings are held each quarter, and participating members learn about programs, benefits and services from health plan staff. Members provide input and offer feedback on issues of importance to them. All Molina members and/or their caregivers are welcome to join. For more information on how to join, please encourage them to contact:

- SCO Member Advisory Committee – **Frances.Prutsman@MolinaHealthcare.com**
- One Care Member Advisory Committee – **Kalise.Osula@MolinaHealthcare.com**