Enhanced Care Management

Provider Manual

Part 1

(CCA Users)

Molina Healthcare of California

(Molina Healthcare or Molina)

2025

Capitalized words or phrases used in this ECM Provider Manual shall has the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" has the same meaning as "Health Plan" in your Agreement. The ECM Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current ECM Provider Manual at MolinaHealthcare.com.

Last Updated: 09/2025

Enhanced Care Management Provider Manual

The Molina **Enhanced Care Management (ECM) Provider Manual** serves as the reference guide for ECM Providers and is considered an extension of the Provider contract. The manual details processes and requirements for the administration and delivery of Molina's Enhanced Care Management Program (ECM). ECM Providers are required to review this manual, participate in associated trainings, share materials with existing and new staff, and educate on program requirements. The information contained in the manual is current as of the date of its publication and is subject to change based on new DHCS requirements and/or when changes are made to Molina's ECM processes.

Please contact Molina's ECM Team at: MHC_ECM@MolinaHealthcare.com for questions about the manual or the ECM Program.

Thank you for your partnership and service to our members!

MOLINA® HEALTHCARE

Table of contents

Enhanced Care Management | Overview and Requirements

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems (DHCS ECM Policy Guide, section: What is Enhanced Care Management). ECM is a statewide Medi-Cal benefit offered at no cost to all eligible Medi-Cal members as defined by the DHCS ECM Policy Guide.

Populations of Focus: To qualify for the ECM benefit, Members must meet the DHCS ECM eligibility criteria for at least one of the Populations of Focus (PoFs) below:

- Individual adults experiencing homelessness
- Adults with families or unaccompanied children/youth experiencing homelessness
- Adults at risk for avoidable hospital or emergency department (ED) utilization
- Adults and children/youth with serious mental health and/or substance use disorder needs (SUD)
- Adults living in the community and at risk for long-term care institutionalization (LTC)
- Adult nursing facility residents transitioning to the community
- Adults and youth transitioning from incarceration
- Pregnant and postpartum individuals (Birth Equity)
- Children/youth enrolled in California Children's Services (CCS) with additional needs beyond the CCS condition
- Children/youth involved in child welfare
- Children/youth at risk for avoidable hospital or (ED) utilization

Goals: The ECM benefit is designed to offer comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

Services: ECM offers a core set of seven services to help members manage and improve their health

1. **Outreach and Engagement:** Contact and engage the member in their care.

2. **Comprehensive Assessment and Care Management Planning:** Complete a comprehensive assessment with the member and work with them to develop a care plan to manage and guide their care and meet their goals.
3. **Enhanced Coordination of Care:** Coordinate care and information across all of the member's providers and implement the care plan.
4. **Health Promotion:** Provide tools and support that will help the member better monitor and manage their health.
5. **Comprehensive Transitional Care:** Help the member safely and easily transition in and out of the hospital or other treatment facilities.
6. **Member and Family Supports:** Educate the member and their personal support system about their health issues and options to improve treatment adherence.
7. **Coordination of and Referral to Community and Social Support Services:** Connect the member to community and social services.

ECM Exclusions and Other State Programs/Benefits | Non-Duplication

There are many programs, services and benefits offered to Medi-Cal members designed to coordinate care for eligible individuals. Molina and ECM Providers work together to ensure that services are not duplicated, and appropriate referrals are made when indicated. In some instances, members may receive services from more than one program, including ECM. However, there are other cases where the members cannot be enrolled in ECM if they are already enrolled in another program. The following highlights the intersection of ECM and certain benefits and services or programs. For further detail and a more exhaustive list, please reference the DHCS ECM Policy Guide.

- **1915(c) Waiver Programs:** Members can be enrolled in a 1915(c) Waiver Program or ECM, but not in both at the same time.
- **California Community Transitions (CCT) Money Follows the Person (MFTP):** Members can be enrolled in CCT MFTP or ECM, but not in both at the same time.
- **Hospice:** Members receiving hospice are excluded from ECM.
- **Family Mosaic Project Services:** Members enrolled in Family Mosaic Project Services are excluded from ECM.
- **Complex Case Management (CCM) and ECM:** Members can be enrolled in either CCM or ECM, but not in both at the same time.
  - **Accordant:** Members can be enrolled in either Accordant or ECM, but not in both at the same time.
- **Community Health Worker (CHW) and ECM:** CHW services are considered a built-in component of ECM. CHW services are not separately reimbursable for members enrolled in ECM.
- **Dual Eligible Members:**

Medicare Delivery Model	ECM Eligible
FIDE-SNPs	No (b/c similar provided)
PACE Programs	No (b/c similar provided)
Medi-Medi Plan (i.e. Medi-Cal MCP + EAE D--SNPs)	No (b/c similar provided)
Medi-Cal MCP + non-EAE D-SNP	Yes in 2023; No for 2024, because Medi-Cal MCP Member will receive ECM-like services from D-SNP *(Unless the Member was already receiving ECM services at the end of 2023)*
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	No

MOLINA HEALTHCARE

ECM Provider Roles and Responsibilities

Each eligible member is assigned to a contracted ECM Provider who is responsible for the provision of ECM services, including designating an ECM Lead Care Manager (ECM LCM) to serve as the primary point of contact and coordinator for the member, their providers, and personal support system.

If a member's primary care provider is affiliated with an ECM provider organization, the member will be assigned to that ECM provider whenever possible. If a member's primary care provider is not part of an ECM provider organization, the ECM provider is assigned based on PoFs served, experience and service area. The assigned ECM provider must coordinate with the member's primary care provider and all providers that are part of the member's care team.

A member can also choose a different ECM provider organization or a different lead care manager within their assigned ECM provider organization if they want.

ECM provider responsibilities include:

- Reaching out to the member to initiate care.
- Conducting ongoing outreach and engagement with each member, primarily through in-person contact or the member's preferred method of communication.
- Ensuring that services are provided monthly or more frequently the member's needs.
- Assigning a lead care manager to each member in CCA within 5 business days, see page 24 for steps on how to assign an ECM LCM to a member.
- Working with a member and their care team to conduct a comprehensive assessment and develop and update a care plan for each member.
- Organizing member care activities and maintaining regular contact, which includes proper CCA documentation, with their providers to ensure coordination, including county substance use disorder and specialty mental health providers as appropriate.
- Managing referrals, coordination, and follow-up to needed services and supports.
- Supporting the member in making healthy choices and strengthening skills that allow them to better manage their conditions.
- Supporting the member and their personal support system during discharge from the hospital and other treatment facilities.
- Providing education and identifying support needs for a member and their family or other caregivers.
- Providing services in person and accompanying members to appointments when needed.
- Sharing information and reports with the health plan and submitting claims and/or encounters.

ECM providers must meet certain qualification requirements to serve ECM enrollees, such as those related to experience, capacity, and documentation.

Care Management Documentation System Requirements

Clinical Care Advance (CCA)

ECM Providers who choose to utilize Molina's care management platform will need to document all member activities in Clinical Care Advance (CCA). CCA documentation is considered the source of truth for all ECM-related member activities and is subject to regulatory/internal audits. When requesting access to CCA, a supervisor or above must complete the *ECM-CS CCA External Access Request Form* and submit it to Molina's ECM Team: MHC_ECM@MolinaHealthcare.com. The ECM-CS CCA External Access Request Form must be completed in its entirety and accurately, especially the User Type section (Non-Clinical or Clinical), as this impacts our encounters submissions. We want to ensure we are correctly reporting encounters made by non-clinical staff versus clinical staff.

In the event that someone from your organization leaves or no longer needs access to CCA, your organization will need to inform Molina's ECM Team immediately to disable the user's access.

Logging into CCA

1. Pre-requisites
   a. Supported Browser(s): Clinical Care Advance **only** works in **Microsoft Edge** and in **Chrome**
2. Paste the following link careadvance.molinahealthcare.com/ into the Microsoft Edge browser address bar to log into the Care Clinical Advance Production Environment.
3. **If you are a first-time user, you must change your password** before Logging in to Clinical Care Advance. Please Click on Change your Password to change your password.

4. Please type in username prefixed with **Molina.dmz**username and password received in your email. Type your new password in New password and Confirm the new password. Click on **Submit** to update your Password.

Note:

- To change password please email MHC_ECM@MolinaHealthcare.com. The "change your password" buttons will not work.
- Your username is not your email. In most cases, it will be the first four letters of your last name followed by the first four letters of your first name.
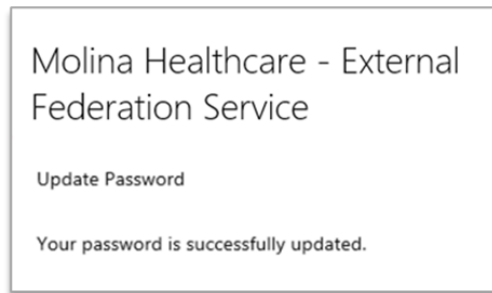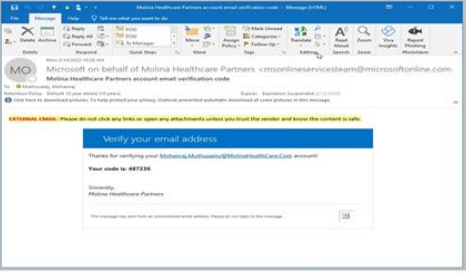

5. Copy and paste the link below into the Microsoft Edge browser address bar to return to the Login for the Care Clinical Advance Production Environment.
careadvance.molinahealthcare.com/
6. Please Type in your username **without the prefix Molina**, then type in your new password. Click **Sign in** to Log in.
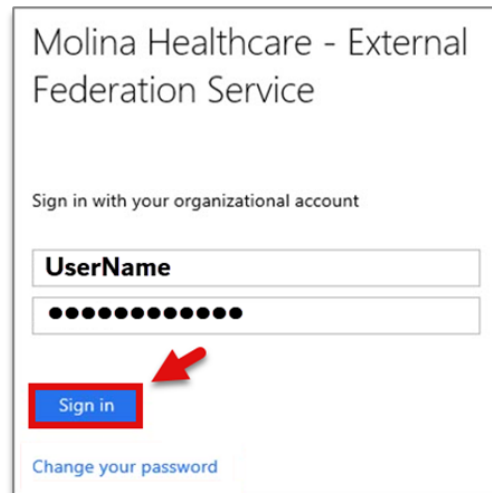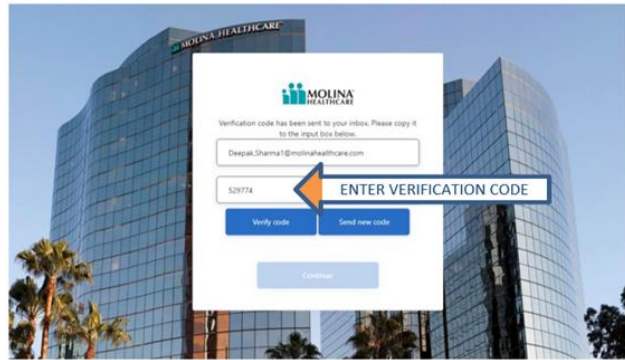

7. You are now in the CCA Production Environment. This is where all our active members live. Any completed action or process is all done here in the production environment.

CCA 2FA Steps

Instruction	Screen Shot
Step 1: Open Microsoft Edge or Chrome. Copy the link below to the browser URL to access CCA careadvance.molinahealthcare.com	
Step 2: The user is redirected to the Molina Login screen (SSO) Enter Molina user credentials • Username: Enter Username (please refer to new user credentials email) • Password: Enter Password (******) • Click on the sign-in button	
Step 3: The user will be prompted to send 2FA code to the user's registered work email:	
Step 4: After clicking on the send verification code button, 2FA code will be sent to the user's work email in 1-2 minutes (will be valid for 5 minutes)	*If user does not receive email within 2 mins, check junk mail. If email is not received, reach out to internal IT team to ensure email is not blocked.*

9

MOLINA HEALTHCARE

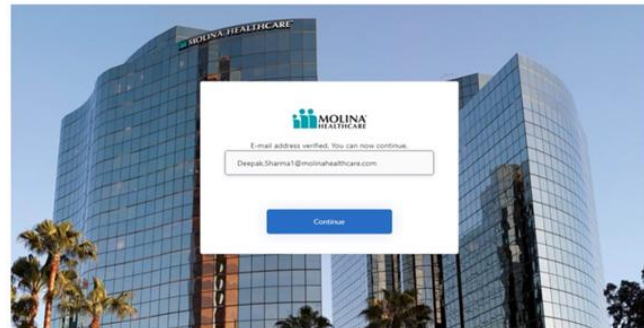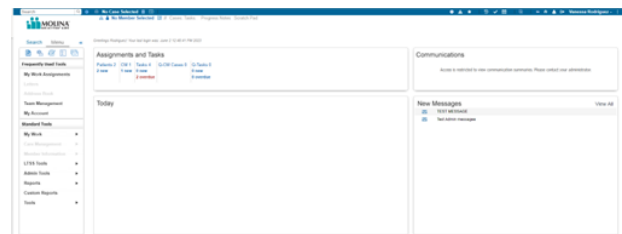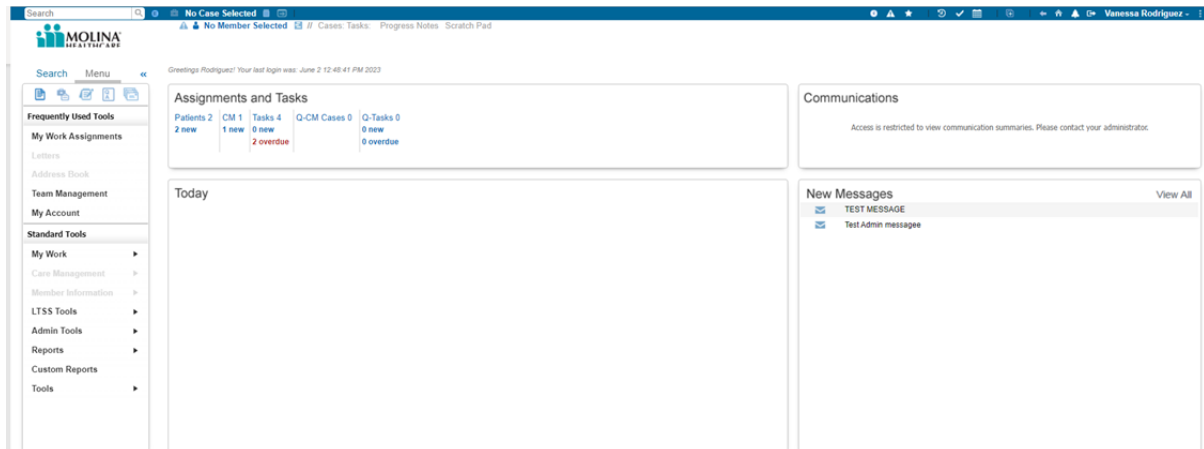|	
Step 5: Enter 2FA code received from the email	
Step 6: Click on Verify code	
Step 7: A success message is shown after the email is verified. Click Continue to log into CCA	
Step 8: Successful login to Clinical Care Advance (CCA) application	

Basic Navigation of CCA

Today's Section in CCA

The Today section of the CCA home page displays company-wide announcements or messages regarding any new CCA system activities (i.e., campaigns, reports, new features, updates, etc.).
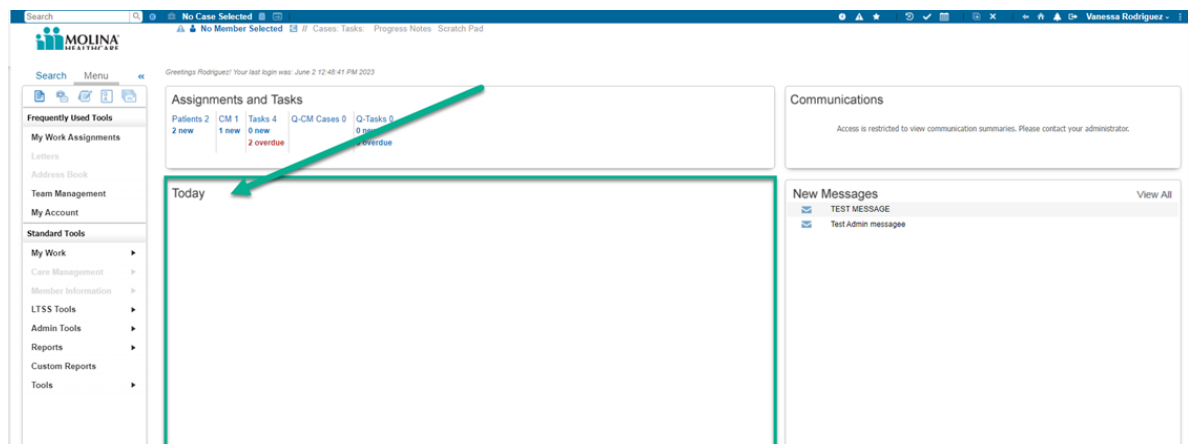
Assignments & Tasks

1. **Patients:** Displays user's <u>Current Caseload</u>, total # of members (patients) assigned to users & # of new members assigned **(bolded).**

2. **CM:** Allows the user to view their <u>Current Case Management</u> # of opened CM cases and new CM cases assigned **(bolded)**.
3. **Tasks:** Shows # of tasks assigned to the user (both **new** and **overdue**); the last two columns not used (not applicable to ECM).

Searching for and Selecting Members in CCA

Many CCA functions work directly with a member's record, so you must find and select the member to "**bring them into focus**." In the Search tab, you need to enter the information you have for the member. Please only look up members assigned to you by Molina ECM Team, otherwise this is considered a breach in privacy.

Instructions	Screenshot
Step 1: Select **Search** from the Vertical Menu Bar to bring up the search menu. **Note:** • If the member is not in focus (as seen in the screenshot as "No Member Selected"), some of the menu options will be grayed out. • The Admin Tools section is for the Molina internal teams. Please do not use this feature.	

Step 2:

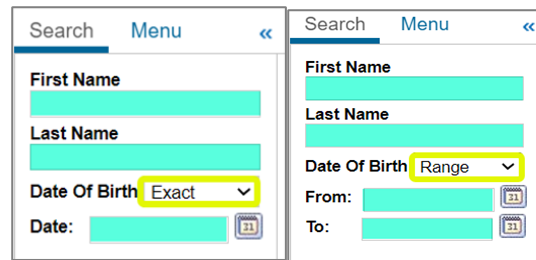There are two (2) ways to search for members:

Option #1 –

The first way is to enter the member's first name, last name, and date of birth. Select the **Exact** Date of Birth from the dropdown if you have the member's birthdate. Select **Find.**
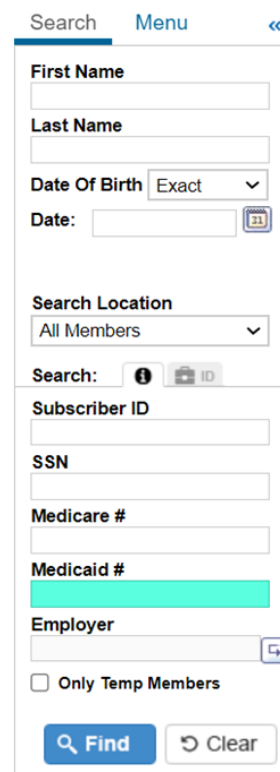
                    or

Select **Range** from the dropdown if you do not have the Date of Birth, but you have an approximate age range; enter those dates and select Find.

Option #2 –

The second way to search for a member is to enter their Medicaid ID, also referred to as the member's CIN. Select **Find.**

Note: When searching by first and last name, a minimum of two (2) is required.

MOLINA
HEALTHCARE

Step 3:

Once the list of members populates, click the **member's name** to bring the member "**IN FOCUS**."

Note: If a member is restricted, you cannot access the member's CCA profile. Members might be restricted because they are no longer with our plan or might have a hold restriction. If this is the case, please check Availity (the new Provider Portal). Other reasons might be that the member was disenrolled from the ECM Program or missing a condition code to allow the ECM Provider to access the member. Reach out to Molina's ECM Team Inbox immediately if this occurs. Molina's ECM Team will troubleshoot the issue.

Search Results

Member Dashboard   Add Temp Member   Assign Member ▼

YOU SEARCHED FOR: members whose first name begins with test

First Name	Last Name	Date of Birth	Subscriber ID	Group ID	Employer	SSN	Medicare #
TEST	STAGECL	12/02/1981	******	******	TX	******	******
TEST	TESAS	12/02/1981	******	******	TX	******	******
TEST	TEST	01/01/1987	******	******	FL	******	******
TEST	TEST	01/01/1990	******	******	UT/NV	******	******
TEST	TEST	01/01/2001	11858242		CA		
TEST	TEST	01/01/2001	11858357		CA	3123	
TEST	TEST	01/01/2001	11924506		CA	3123	
TEST	TEST	01/31/1995	******	******	TX	******	******
TEST	TEST	02/04/1982	******	******	FL	******	******
TEST	TEST	02/11/2007	******	******	MI	******	******
TEST	TEST	04/11/1986	603839784		CA	5732	
TEST	TEST	08/18/1968	******	******	WI	******	******
TEST	TEST	10/10/2000	000000000		CA	0000	
TEST	TEST	11/11/1990	******	******	TX	******	******

PREVIOUS | NEXT

MOLINA HEALTHCARE

Member Banner

When a member is '**in focus,**' the member's name appears at the top of the screen in the Member Banner. The Member Banner displays two lines of important information about the member.

Top Line: Displays general information about the member in focus.

1. Member's name
2. Member's Dashboard icon
3. Gender, Age
4. DOB
5. Molina ID#
6. Member's cases (you can click here to view the member's case history)
7. Tasks associated with the member (you can click here to view all tasks associated with the member)
8. Progress notes
9. County, Primary language

Bottom Line: Includes the member's Eligibility Information. You want to always look at the member banner when bringing a member into focus to see if the member is **eligible** for ECM and whether the member is **enrolled (or Opted In).**

1. **Line of Business** (LOB) or **Product Description**. Please note, member eligibility is ever-changing. Please note: All Medi-Cal members in LA County are Health Net members delegated to Molina.
2. **Enrollment** & **Termination** date with Molina *(12/31/2078 is the default if there is no active termination date).*
3. **The Redetermination Date** is a future date that indicates when the member's Medicaid eligibility must be renewed with the state.
4. **ECM Program Information** – ECM Eligibility | ECM Enrollment Status. Here is where you can find information on whether a member is eligible for ECM and if the member is or is not enrolled in ECM.
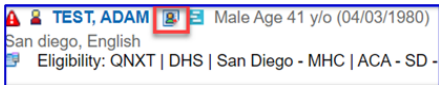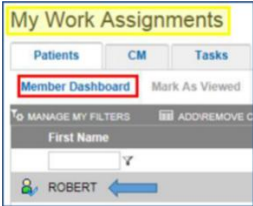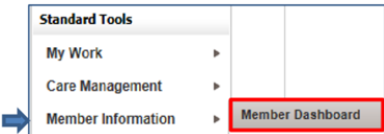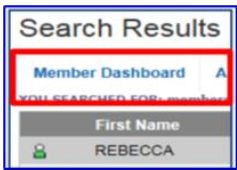
Member is NOT Enrolled in ECM (NOT Opted-In)	Member is Enrolled in ECM (Opted-In)

Member Dashboard

The Member Dashboard contains a summary of member data and quick access to detailed information for a specific topic. ECM Providers should be reviewing the Member Dashboard as part of their pre-call review exercise (see Pre-Call Review section for additional details). In addition, if an ECM Provider cannot reach a member due to insufficient contact information, they should review the Member Dashboard for additional member contact information.

To access the Member Dashboard:

Instructions	Screenshot
Step 1: Bring a member in focus.	
Step 2: There are four (4) ways to access the Member Dashboard. **i.** The icon by member's name (displays Member Dashboard in a separate pop-up window) *Recommended* **ii.** Member Dashboard tab under "My Work Assignments" (changes the main screen to Member Dashboard) **iii.** Member Information -> Member Dashboard (changes the main screen to Member Dashboard) iv. Search Results – *When searching for a member, this section lets users view the dashboard once the member is selected.*	**Recommended** i. ii. iii. iv.

The Member Dashboard is organized into sections. *Header, Demographics, and Summary* are located at the top of the page to provide quick views of member information.

Example of the Demographics and Summary Sections of the Member Dashboard

Note: The Member Dashboard information is *VIEW ONLY.*

- When viewing a category in the Member Dashboard (e.g., Recent Activities), you can only view a maximum of five (5) entries. To view all entries, click on **View All.**

Note: If you click on **View All,** the main screen in the background or on another monitor will change to show that section you wish to view to allow you to view all entries.

Member Dashboard Sections		
Active Cases	HCC Information	Member Claim – Details
Active Coverages	Imported Guidelines	Personal Contacts
Additional Information	Indicators	Procedures
Allergies	Medications	Recent Activities
Assignments	Member Care Data - Alert Summary	Recent Assessments
Conditions	Member Care Data – Authorization	Recent Tests
Costs Summary	Member Care Data – Behavioral Summary	Summary
Custom Fields	Member Care Data – ED Summary	Time Log
Demographics	Member Care Data – Inpatient Summary	Treating Provider
Eligibility-Additional Attributes	Member Care Data – Office Visit Summary	Triage Reasons
Eligibility-Relationship	Member Care Data – Other Claims Summary	Utilization Active Authorization
Eligibility-Restriction	Member Care Data – Communication Summary	Utilization Inactive Authorization
Episodes	Member Care Data – Immunization Summary	Vaccinations
Care Gaps		

MOLINA HEALTHCARE

Address Book

ECM Providers can find their assigned member's contact information (referred to as *My Information* in CCA), as well as the member's mailing information and the member's Primary Care Physician contact information. If a member has secondary insurance with Molina, this information might not be available in CCA, please ask the member to provide you with their PCP's information and add them to the Address Book. However, if a member needs to update their contact information and/or PCP information, in that case, the ECM LCM needs to assist the member with changing this information by calling Molina's Member Services.
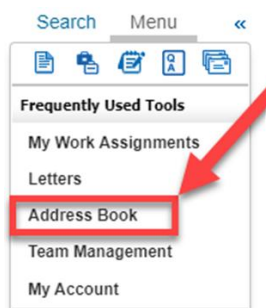
Address Book in CCA

Create New Contact	Update Contact Information		
NAME	TYPE		ADDRESS
	Primary care physician		
	ECM Lead Care Manager		
	My Information		
	Mailing		

The assigned ECM LCM must enter their contact information within <u>five business days</u> of enrolling the member in the Address Book. Per new CLR requirement, ECM LCM MUST include their extension number in the Country field. Please see below for instructions on how to complete this field.

The ECM LCM should enter any pertinent contact information in the Address Book, such as Interdisciplinary Care Team (ICT) members.

Follow the steps below to add the ECM LCMs contact information to the Address Book, however, follow the same steps to add additional contacts:

Instructions	Screenshot
Step 1: Access Module There are multiple ways to access Address Book; the shortcut is displayed. Click on **Address Book**	

MOLINA HEALTHCARE

Step 2: **Click on Create New Contact**	**Address Book - Personal Contacts** **Create New Contact** **Update Contact Information**
Step 3: Choose Contact Type from the drop-down list: Select **ECM Lead Care Manager** • For member contacts, select **Personal Contact.** • For PCP and specialists, select **Specialist**. • Select **Other** for the other options that are not listed. Fill out the rest of the form as appropriate. **IMPORTANT:** In the last name field, place the name of the organization the individual being added belongs to in parenthesis. Example: **Smith (PICF)** To finish, click **Save** Once completed, the new contact(s) will be displayed in the **Address Book – Personal Contacts** window.	**Contact Type** Dental Insurance Pharmacy Dentist OB/GYN Specialist 3 Specialist 4 Specialist 5 Therapist Vendor Power of Attorney Personal contact 3 Personal contact 4 Member Representative Health Department Personal contact 5 Family Member Home Health Personal contact 1 Personal contact 2 HIPAA Address Legal Guardian Emergency Contact Ophthalmologist Member Bad Address HHP Care Coordinator Housing Specialist Case Manager Provider Bad Address Tribal Affiliation ECM Lead Care Manager **Address Book - Personal Contacts** **Create New Contact** **Update Contact Information** | NAME	TYPE
Maria Gray	PCP
Maria Smith (PICF)	ECM Lead Care Manager
Joe Smith (Step Up on Second)	Housing Specialist	

MOLINA® HEALTHCARE

Please note: Per new CLR requirement, ECM LCM MUST include their extension number in the Country field.

Enter the direct business line telephone extension to the ECM LCM at the care facility. Add "x" before extension number.

Select the Contact Type from the drop-down

Be sure to enter the name of the organization the individual being added belongs to in parentheses ()

Be sure to add the LCM's extension number in the country field

Please note:

Only manually entered contacts in the Address Book can be **edited** or **deleted**.

ECM Lead Care Manager Caseload

As part of ECM's Program Requirement, Molina allows a maximum caseload of 50 members per ECM Lead Care Manager at any given time. This means a 50:1 ratio of members to ECM Lead Care Manager. Molina defers to the ECM Provider to decide on the minimum caseload. If any of your ECM Lead Care Managers have a caseload larger than 50 members without prior approval from Molina, Molina will stop assigning members to your organization. Please monitor your caseload on a regular basis as part of your oversight and monitoring.

Assigning an ECM Lead Care Manager to an Enrolled Member
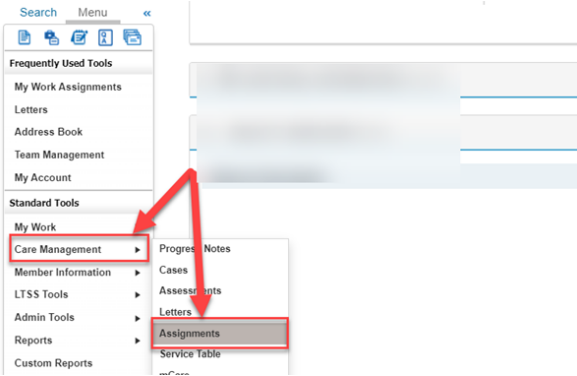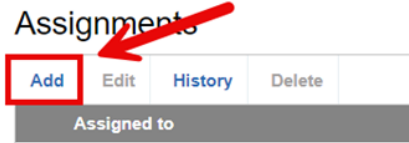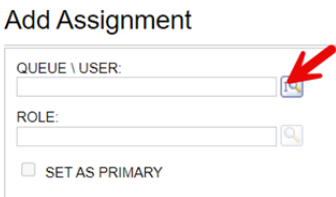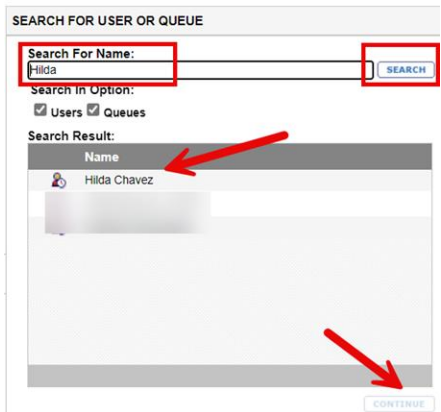
As mentioned above, once a member has been enrolled into ECM, the ECM Provider must assign an ECM Lead Care Manager (LCM) within 5 business days from the enrollment date. If the assigned ECM LCM leaves the organization, the ECM Provider must immediately reassign the member to another ECM LCM. ECM Providers must enter the ECM LCM's contact information in the Address book in CCA and assign the ECM LCM as the Primary CM under the Assignments in CCA; the ECM LCM entered in both sections needs to match. If your organization reassigns any of our members to a different ECM LCM in the future, those updates need to be reflected in CCA immediately. Please note, this is also an ECM Program Requirement.

Before disenrolling a member, the ECM LCM needs to remove their contact information from the Address Book and remove themselves from the Assignments in CCA.

MOLINA®
HEALTHCARE

Adding and Removing Assignments in CCA

Follow the steps below to assign a member to your caseload or another ECM staff:

Instructions	Screenshot

Step 1:
 	
Once the member is selected and in focus, go to the **Care Management** tab under Standard Tools to assign the member to a CM staff or yourself.
 	
    a.   Click Care Management
    b. Click Assignments	

Step 2: Click **ADD**.	
Step 3: Under **QUEUE\USER**, click on the magnifying glass	
Step 4: Enter the staff name and select **SEARCH**. Search results will populate staff names. Select the appropriate staff name and then click **CONTINUE**.	

MOLINA HEALTHCARE

Step 5: Under **ROLE**, click the magnifying glass and select the appropriate role. If the staff is the primary case manager, check the box **SET AS PRIMARY**; otherwise, leave the box empty. **The ECM LCM is required to select SET AS PRIMARY.** Click **SAVE**	Add Assignment QUEUE \ USER: Hilda Chavez ROLE: Case Manager ☑ SET AS PRIMARY Save Cancel

MOLINA®
HEALTHCARE

Deleting Assignments in CCA
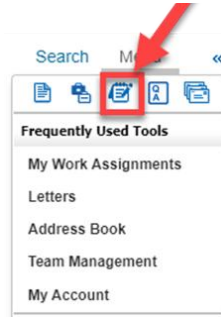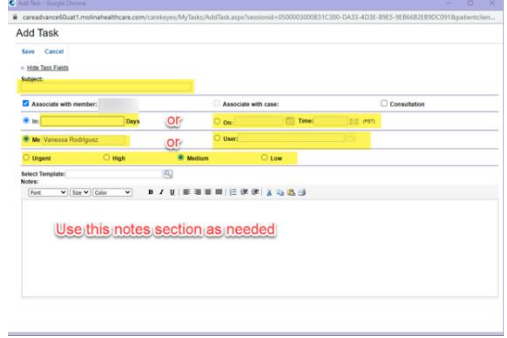
Follow the steps below to delete yourself or someone else from the member's Assignment in CCA. ECM LCMs are required to do this before disenrolling a member & when reassigning a new ECM LCM to a member:
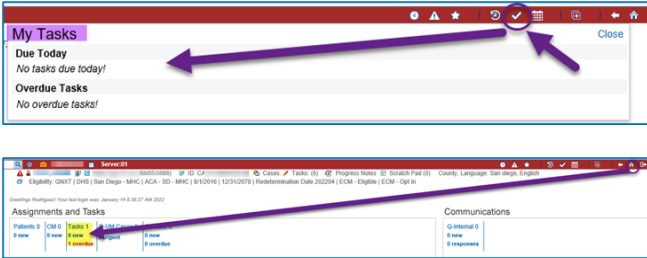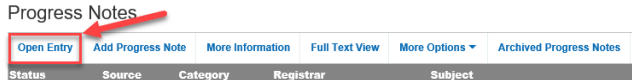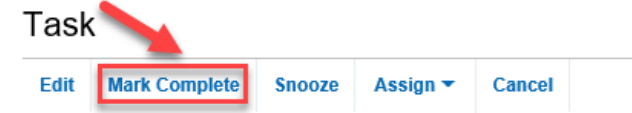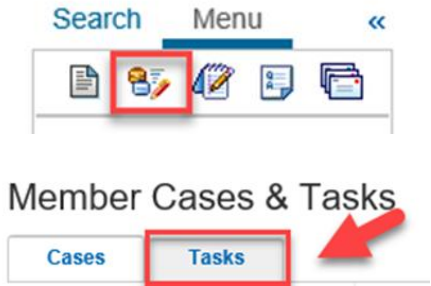
Instructions	Screenshot
You can remove a member from your caseload by going to Case Management – Assignments. Select your name and click [**DELETE**] -> [**OK**].	Assignments Add Edit History Delete Assigned to Hilda Chavez NOTE: **Cannot remove assignment if there is an open case.**

MOLINA®
HEALTHCARE

Task Function

Tasks are reminders for the external user to complete or follow up on certain action items (i.e., UTC follow-up attempts, assessments to be completed, follow-up calls to members/providers, sending correspondence or educational materials, scheduling case conferences, ECM care plan updates, as applicable housing voucher renewal application, etc.). ECM Providers documenting in CCA are required to use the task function for all action items, including but limited to the Comprehensive Assessments and Reassessment, and if the member requested the Advance Directives booklet in another language as discussed during the completion of the Comprehensive Assessments. Before disenrolling a member, the **ECM LCM is required to close all pending tasks.**

Below are the steps for creating a task and how to view tasks in CCA:
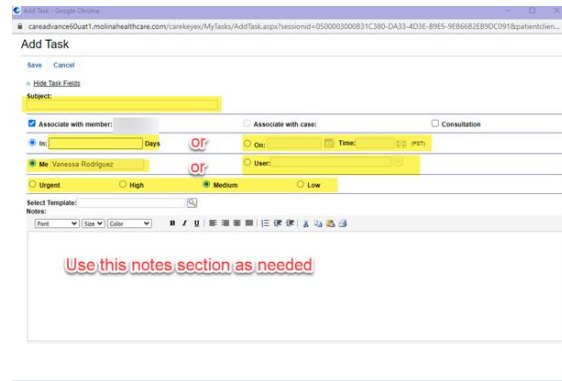
Instructions	Screenshot
Step 1: There are multiple ways to create Tasks These steps are for creating Tasks from the **Progress Notes module.** Click on the notepad icon.	
Step 2: Bring an entry into focus (gray-out) & click on Add Reminder or Task	
Step 3: **Fill out highlighted items as appropriate** A task can be assigned to yourself- "Me," or another "User" in CCA.	

MOLINA HEALTHCARE

Step 4: Select **Save**	Add Task Save Cancel
Step 5: To check your **Tasks**, click on the check mark at the top-right-hand corner or the Home icon at the top-right-hand corner.	
Step 6: When the Task has been completed, the user can click on the **Task, Open Entry,** and choose **Mark Complete**	

<table>
<tr><td colspan="2" style="text-align:center;background:#1b9ba5;color:#fff;">Creating Tasks From The Member Cases & Task Module</td></tr>
</table>

Step 1: Click on the briefcase icon and then select the Tasks tab	
Step 2: Select **Add Task**	

MOLINA HEALTHCARE
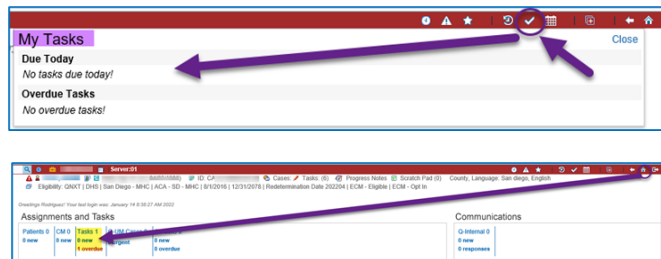
Step 3: **Fill out highlighted items as appropriate** A task can be assigned to yourself, "Me," or another "User" in CCA.	
Step 4: Select **Save**	
Step 5: To check your **Tasks**, click on the check mark at the top-right-hand corner or the Home icon at the top-right-hand corner.	
Step 6: When the Task has been completed, the user can click on the **Task** and choose **Mark Complete.**	
Adding a task from the Task Calendar	
Step 1: Adding a task from the Task Calendar. Select the calendar icon on the top right hand section of CCA.	
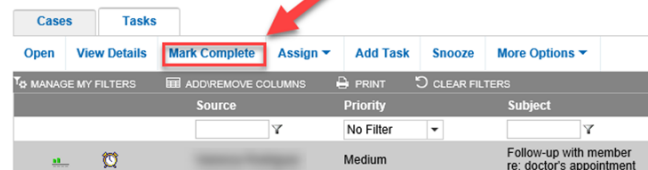
MOLINA HEALTHCARE

Step 2: Select "**Add Task**" You can also change the format of the calendar (day, weekend work, etc.)	
Step 3: **Fill out highlighted items as appropriate**. A task can be assigned to yourself, "Me," or another "User" in CCA.	
Step 4: Select **Save**	
Step 5: Select the calendar icon on the top right-hand section of CCA. The calendar will appear with the task you added. You can open the task by double-clicking on it and you can work on the task (like editing it) too when doing this.	 Task Calendar

MOLINA HEALTHCARE
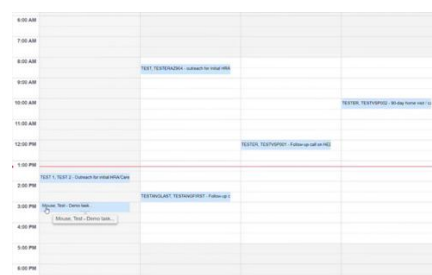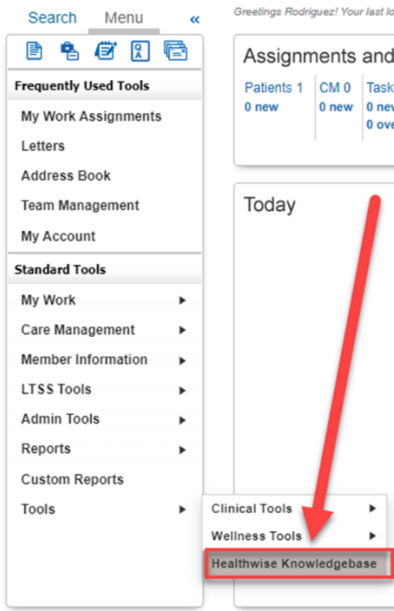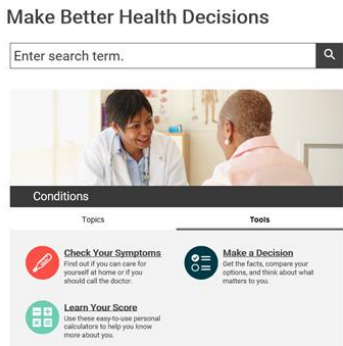
Healthwise Knowledgebase

Healthwise Knowledgebase is a resource our ECM Providers can utilize to review and pull educational materials to support our members in learning and adopting healthy lifestyle choices. Follow the steps below to access Healthwise Knowledgeable in CCA:

Instructions	Screenshot
Step 1: Under the Menu, access the Tools module Select **Healthwise Knowledgebase**	
Step 2: The following screen will appear	

MOLINA
HEALTHCARE

Step 3:

Browse or search topics of choice. See the sample in the screenshot.

Step 4:

Click on the desired link, and a webpage will appear. This information can be printed by clicking on the printer icon.

Enter search term. [🔍]

‡ En español

Type 2 Diabetes

What is type 2 diabetes?

Type 2 diabetes is a condition in which you have too much sugar (glucose) in your blood. Glucose is a type of sugar produced in your body when carbohydrates and other foods are digested. It provides energy to cells throughout the body.

Normally, blood sugar levels increase after you eat a meal. When blood sugar rises, cells in the pancreas release insulin, which causes the body to absorb sugar from the blood and lowers the blood sugar level to normal.

When you have type 2 diabetes, sugar stays in the blood rather than entering the body's cells to be used for energy. This results in high blood sugar. It happens when your body can't use insulin the right way.

Over time, high blood sugar can harm many parts of the body, such as your eyes, heart, blood vessels, nerves, and kidneys. It can also increase your risk for other health problems (complications).

Condition Basics

Health Tools

Cause

What Increases Your Risk

Prevention

Symptoms

MOLINA HEALTHCARE

Member Information File (MIF)

The primary mechanism for Member identification should be referrals from the community. DHCS expects managed care plans (MCPs) to source referrals from a variety of entities, including but not limited to, network providers (PCPs and specialists), community-based organizations, ECM, and CS providers.

During the onboarding process, Molina's ECM Team will request the parameters needed to generate a Member Information File (MIF) tailored to the expertise and experience of the ECM Provider. Parameters include Populations of Focus (PoF) they service, zip codes, Tax IDs, age, capacity, etc. This will ensure proper member assignment during the MIF process and for referrals. If the ECM Provider decides to change their MIF parameters, they must inform Molina's ECM Team immediately. Refer to the current DHCS ECM Policy Guide for a list of Populations of Focus. (CALAIM ENHANCED CARE MANAGEMENT POLICY GUIDE, Updated August 2024):

ECM Populations of Focus
Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*
Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*
Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)
Individuals with Serious Mental Health and/or SUD Needs
Individuals Transitioning from Incarceration
Adults Living in the Community and At Risk for LTC Institutionalization
Adult Nursing Facility Residents Transitioning to the Community
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
Children and Youth Involved in Child Welfare
Birth Equity

ECM Providers will utilize their MIF to outreach their assigned ECM-Eligible members and will outreach all members in their MIF within **five business days of receipt of the MIF**. Regardless of the outcome, all outreaches need to be documented via a Contact Form in CCA. Moreover, irrespective of the outcome (e.g., the member agrees to participate in ECM, the member

declines ECM, the member is not enrolled due to being unable to contact, the member does not meet any Population of Focus criteria, or the member is in a duplicative program), the ECM Provider needs to complete a Closed Loop Referral Form in CCA. (See below page 58 for more on CLR).

ECM Providers are required to complete at a minimum of **five outreach attempts** as follows:

- Four non-mail attempts (recommended that one of the non-mail attempts is a face-to-face visit)
- Final attempt is a mailed ECM Generic UTC letter for members who are unable to be reached, with the exception of members experiencing homelessness.

Outreach Protocol:

- ECM Providers should begin outreaching their MIF members within five business days of receipt of their MIF
- The **five outreach attempts** should be completed within **60 calendar days** from receipt of the MIF
- Attempts should be made on different days and times using at least three different modalities (in-person, phone, and email).
- If you cannot contact the member (UTC) at any point prior to or after enrollment, ECM Providers are required to research additional contact information:
  - Review of available notes (auth notes, admission/discharge notes),
  - Call PCP and pharmacy,
  - Make a direct referral to the Member Location Unit (TMLU) ,etc.
- This should be documented via a contact form in CCA with the appropriate outcome and correct UTC letter sent.

MOLINA
HEALTHCARE

ECM Referral Forms

An ECM referral form is required for eligible members who are not included in a Member Information File (MIF). Molina accepts all ECM referral forms. Molina's latest ECM Referral template is located on [Molina's website](). Molina applies a "No Wrong Door" policy for referrals to ECM. Network providers, including PCPs, specialists, hospitals, etc. may refer members to ECM. Members may self-refer or be referred by their representative, parents, caregiver, or legal guardian.

Please note:

- To be eligible for ECM, members must be enrolled in Medi-Cal Managed Care with Molina, meet criteria for one or more of the identified ECM PoFs, without hold restrictions, and must not be enrolled in exclusionary programs or receiving duplicative services.
- There are two separate ECM referral forms – one for adults and the other for child/youth (see links below).
    - **Adult ECM Referral form:** [Enhanced Care Management (ECM) Adult Member Referral Form]()
    - **C/Y ECM Referral form:** [Enhanced Care Management (ECM) Child and Youth Member Referral Form]()
- When referring a member to our ECM Program, ensure the referral form is **completed in its entirety,** specifically as it relates to a members Population of Focus, to avoid delays.
- **Routine** referrals will be processed within five business days of receipt while **expedited** referrals will be processed within 72 hours; indicate in the subject line as follows: "<Expedited>/<Routine> ECM Referral – QTY <Insert # of Referrals in the request> - Member Initials - <Name of Organization>". If you have an expedited referral, be sure to include rationale (i.e. Member is about to be evicted, member about to be discharged from hospital, etc.)
- Send all ECM referral forms to our ECM referral inbox at [MHC_ECMReferrals@molinahealthcare.com](). Molina's ECM Team is responsible for reviewing the referral and assigning an ECM Provider to the member.
- Molina's ECM Team will inform the referrer if the referral was approved or denied as well as the ECM provider assignment and effective date.
- Please submit no more than five (5) referrals in one email. This will ensure that referrals are processed more timely, as multiple ECM team members work on referral processing.
- The ECM provider must outreach the member within 5 business days of receiving the confirmation email indicating that the ECM referral has been approved and processed.
- Expedited referrals:
    - Members who are currently in the hospital and meet PoF criteria, who are in need of urgent care coordination through an ECM Lead Care Manager within 72 hours.

o   Members who have a condition that requires outreach and care coordination through an ECM Lead Care Manager within 72 hours.

Newly Assigned Members through an ECM Referral: Molina's ECM Team will process the member referral and determine appropriate ECM provider assignment. Your organization will be notified via secure email once a member has been assigned.

Presumptive Authorization

Under the Presumptive Authorization policy, effective 1/1/2025, ECM Providers may immediately begin rendering ECM services to eligible Molina members and do not need to wait for a response or approval from Molina to start providing ECM services to eligible members who meet Presumptive Authorization criteria. In order to be eligible under Presumptive Authorization, members must meet all of the following criteria:

- Enrolled in Medi-Cal managed care with Molina.
- Not have hold restrictions.
- Is not enrolled in ECM with another ECM provider.
- Meet criteria for one or more PoFs.
- Must not be enrolled in exclusionary programs or receiving duplicative services.

Providers must use Availity Provider Portal to confirm active Medi-Cal status with Molina and ensure that the member is not already assigned to another ECM Provider or enrolled in ECM. If the member is eligible under Presumptive Authorization, the referring ECM provider will be reimbursed for the first 30 days of ECM services, **even if Molina determines that the member is not eligible for ECM upon review of the referral form.** The Presumptive Authorization process is intended to speed up the delivery of ECM services to eligible members and reimburse providers accordingly. **Please note that members who are not enrolled in Medi-Cal with Molina or are already enrolled and receiving ECM services from another ECM provider are not eligible for reimbursement under this policy.**

In the event the Provider fails to comply with ECM requirements outlined in the ECM and Community Supports contract, and any associated guidance issued by DHCS, Molina reserves the right to exclude the ECM Provider from participating in the presumptive authorization process as set forth in the CalAIM Enhanced Care Management Policy Guide.

A referral form must still be submitted to the Molina ECM team to ensure that downstream processes are effectuated (i.e., ECM member flags, provider assignment, etc.) as soon as possible and **no later than 5 working days** before the end of the presumptive authorization period to limit gaps in authorization and reimbursement for ECM services provided to Members. The following considerations apply to ECM Providers:

- If the referred member is already opted-in and assigned to/receiving services from another ECM provider, the referral will be cancelled to prevent disruption in care. In this instance, the member must request the ECM provider change by contacting Member Services at (888) 665-4621, Monday through Friday, from 7 AM to 7 PM. The Member Services team will notify the ECM team of this request, and the change will take effect the first of the following month.
- Please note that members identified in the community may already be identified through the MIF process and assigned to another ECM provider, who is in the process of

outreach. Please verify with the member if anyone has contacted them for ECM as outreach cannot be billed and reimbursed for multiple providers for the same member.

- If the ECM provider has already been providing ECM services to the member prior to referral, the ECM Provider must submit a Presumptive Auth Referral form so our ECM team can backdate to the date the member became ECM Eligible. When completing the Enrollment Assessment in CCA, the ECM Benefit Start Date will be identified as the ECM Eligible date.

MOLINA®
HEALTHCARE

Availity

ECM Providers are required to check member eligibility through Availity (Provider Portal) before working on the member to ensure the member continues to be enrolled with our plan and a Medi-Cal beneficiary. For access to Availity, your organization's administrator (refer to your leadership) should register on: availity.com/molinahealthcare. If your organization's administrator is experiencing issues registering, please connect with your assigned Provider Services Representative (PSR). In addition, prior to submitting any referrals to our ECM Team, ECM Providers should check the member's eligibility in Availity; this will avoid denying referrals for members not enrolled with Molina Medi-Cal.

Please refer to the following links for additional information:

Registration link: Essentials Registration & Support | Availity

- Helpful resources:
    o Register and Get Started with Availity Essentials - Overview
    o Register with Availity in 6 steps: 2022_01_User Registration Infographic_Essentials_HCC-9190-21
    o Availity-Essentials-User-Guide.pdf
- Help with Claims:
    o How to Submit Smart Claims

MOLINA®
HEALTHCARE

Care Coordination Portlet (CCP)

The CCP is an Availity add-on that allows providers to verify if a member is enrolled in ECM and assigned to an ECM Provider.

- If the member shows "No" for ECM Opt In, but also has an assigned ECM Provider, it means that the member is assigned to that provider but not yet Opted In (ECM Eligible).
- If you see this in the CCP, please do not submit a referral form.
- If the member wishes to switch to another ECM Provider, the member can call Molina's Member Services at (888) 665-4621 to request a provider switch.

Direct Referral to Molina's Member Location Unit

At this time, our MLU team is unable to assist with direct referrals. In the meantime, please continue to check Availity, Care Coordination Portlet, and check with the member's PCP. Additionally, you can reach out to the ECM Molina team for more information at MHC_ECM@molinahealthcare.com.

Please note: Make sure you are documenting ALL outreach efforts to locate the member in CCA via a Progress Note as this will be audit requirement.

Please see below guidance on how to submit a direct referral to Molina's Member Location Unit, but please be advised that this process is currently on hold. We will notify our provider when we can resume direct referrals to Molina's MLU team.

Instructions	Screenshot
Step 1: Access the "**Assessment**" Module in CCA (member should already be in focus) There are multiple ways to access Assessments; the shortcut is displayed.	
Step 2: Choose Under Name, type in referral to filter the list Bring in focus Direct Referral – Molina and select: Take Assessment Or Retake if it was previously completed. Retake Assessment	
Step 3: Fill out as shown Click **Continue**	

MOLINA HEALTHCARE

Step 4:	Direct Referral
Fill out as shown:	
Click **Continue**	

Step 5:	Direct Referral
The referral to the MLU has been submitted. Be on the lookout for any tasks from the Member Location Unit.	
Click **Continue**	

MOLINA® HEALTHCARE

ECM Provider Sample Telephone Outreach Script

Molina created the following outreach script for ECM Providers to utilize when outreaching members for enrollment into ECM. ECM Providers are encouraged to use this script:

Hi, this is [CALLER NAME] with [ORGANIZATION NAME] here in [COUNTY OR TOWN]. Am I speaking with [MEMBER NAME]? *(Verify demographics here- DOB, Address, County, etc.)*

I am calling because you have qualified to now receive a free additional program as a part of your Medicaid health insurance through Molina Healthcare. I'd like to share more about this program with you.

The program I am calling about is Enhanced Care Management. The program helps you to manage your health better as our care coordinator will work closely with your healthcare providers.

We can help with:

- Referral to community support services, such as housing tenancy & sustaining services.
- Find and apply for low-cost or free community programs and services, including food benefits.
- Set up appointments and find doctors
- Schedule transportation and go with you to doctor visits
- Better understand your medications
- Get follow-up services after a hospital stay

Depending on your health conditions and circumstances, we can meet you at your preferred setting, home, doctor's office, or community. This is what makes Enhanced Care Management different from other programs.

Would you like me to schedule a meeting so I can tell you more about the program?

Are there days or times that work better for you? *(Offer an appointment day and time.)* This is the address I have for you [MEMBER ADDRESS].

Would you like me to meet you at this address?

Are there any other phone numbers I can reach you at?

Is there someone else, like a family member, which you would like to be at the visit?

Do I have your permission to contact them? May I have their contact information?

Thanks for your time today. I look forward to meeting you on [DAY] at [TIME].

If something comes up and you need to reschedule, you can reach me at [CALLER PHONE NUMBER]. My name is [CALLER NAME]. I can wait if you want to write this information down.

Thank you for scheduling a visit. Do you have any questions I can answer now?

MOLINA HEALTHCARE

Enrollment in ECM

Your organization is responsible for outreaching to the member and/or member's representative **to complete the ECM Enrollment Assessment in CCA to enroll the member in ECM.**

The member(s) we assign to your organization will reflect in our system as ECM Eligible (not enrolled yet), as of the date you receive the referral notification or MIF from Molina's ECM Team.

See scenarios below for next steps:

1. **Member referred by your organization qualifies and agrees to enroll:**
   - Please confirm the member:
     - Meets at least one Population of Focus.
     - Is still with Molina and has Medi-Cal (verify in Availity).
     - Is not in a duplicative program.
   - Referrals must be sent to the Molina ECM team immediately following the engagement with the member, and no later than 5 business days after first encounter.
   - The Date of Program Discussion (found in the ECM Enrollment Assessment) should be on or after the date the member **identified to be ECM Eligible and referred into the program**.
   - When a member is successfully enrolled in ECM, the **Date of Program Discussion is considered the ECM Opt-In date**.
   - An ECM Lead Care Manager should be assigned in CCA (under Assignments and the Address Book) to the enrolled member within 5 business days of enrollment
   - Complete the Comprehensive Assessment and the care plan within 60 days of enrollment
2. **MIF-Assigned Member who agrees to enroll:**
   - Please confirm the member:
     - Meets at least one Population of Focus.
     - Is still with Molina and has Medi-Cal (verify in Availity).
     - Is not in a duplicative program.
   - Confirm the member agrees to enroll in ECM by completing the ECM Enrollment Assessment in CCA.
   - Use the date you met with the member or member's representative as The Date of Program Discussion (found in the ECM Enrollment Assessment). This will also be the ECM Opt-In date *when you successfully enroll a member*).
   - After submitting the completed ECM Enrollment Assessment in CCA, allow up to 24 hours for the system to refresh.
   - Check the CCA banner after 24 hours to verify the member's status as "ECM Opted-In".

- If the status is not correctly reflecting ECM Opt-in, please email Molina's ECM Team to inform Molina of the issue.
- Please continue to provide ECM services to the member and document in CCA while Molina corrects the member's Opt-in status.
- Assign an ECM Lead Care Manager in CCA (under Assignments and the Address Book) to the member within 5 business days of enrolling the member.
- Complete the Comprehensive Assessment and the care plan within 60 days of enrollment.

Please ensure the following are regularly documented in CCA:

- ECM Enrollment Assessment completion.
- All outreaches to the member via the contact form template in CCA.
    - Timely and complete documentation of contact forms is necessary for appropriate payment via capitation.
    - Please complete one contact form per outreach. Do not consolidate outreaches or anything you do on behalf of the member or for the member.

Reminders:

- Always check member eligibility prior to any outreach to ensure the member is still with our plan and has Medi-Cal.
- Do not assign an ECM Lead Care Manager under the Assignments, and do not add their contact information to the Address Book **unless you are able to successfully enroll the member into the ECM Program.**
- Always confirm receipt of any member referrals Molina sends your team.
- Regularly report your capacity to Molina. If you are not able to take on members due to capacity, please proceed to complete a Closed Loop Referral Form and indicate that your organization does not have capacity. (Example: Service Provider Declined: No Capacity).

Closed-Loop Referrals

Closed-Loop Referrals (CLR) are a key component of DHCS's Population Health Management Program under CalAIM. DHCS defines a Closed-Loop Referral (CLR) as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure. A Known Closure occurs when a member's initial referral loop is completed with a Known Closure reason such as the member receiving services.

The goal of CLRs is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability. The CLR requirements aim to improve MCP information collection, supportive actions on individual referrals, and system -level improvements that will result in Members being connected more quickly to priority services for their health and well-being. MCPs and ECM Providers are required to implement CLR requirements starting July 1, 2025.

CLR Requirements

ECM Providers are required to report the referral status and the referral status date for each member assigned to them, as well as the reason for referral closure and referral closure date via the CLR Form in CCA. A referral status will indicate where the member is in the Closed-Loop Referral Process and is needed for each member assigned to your organization. The goal is to ensure the ECM Provider has closed loop on each member referral. ECM Providers are required to provide the latest Referral Status monthly, on the 25th if the member's status has changed via the CLR Form in CCA. If the status remains the same, do not submit a new monthly CLR form. Molina's ECM Team will review this information and follow up with ECM Providers to ensure compliance with CLR requirements. The updates shared in the CLR Form are submitted to DHCS on a monthly cadence in accordance with regulatory reporting, this is why it's imperative for ECM Providers to submit their data accurately and timely. Failure to comply with CLR requirements may result in the issuance of a Corrective Action Plan (CAP), freeze on member referrals, member reassignments, and even contract termination. Below are the four (4) referral statuses and requirements:

1. **Pending** – Your organization has not decided if they will accept the member referral or if they will be declining it. If this is the case, you will report Pending in the **Referral Status** question and will add the date the member was assigned to your organization on the **Date of Referral Status** field. The date the member was assigned to your organization is found in the MIF. Your organization must decide within three (3) business days of receiving the member referral from Molina's ECM Team if they are accepting or declining the member referral. A member should not have a Pending status no more than (3) business days. **Note:** If you are accepting a member referral, you are required to complete initial outreach within five (5) business days of receiving the member referral.

2. **Accepted** – Your organization accepted the member referral and plans to conduct outreach. If this is the case, you will report Accepted in the **Referral Status** question and

will add the date your organization accepted the member referral under the **Date of Referral Status** field. Please note, your organization must complete initial outreach within five (5) business days of receiving the member referral from Molina's ECM Team, this means a member should not have an Accepted status no more than four (4) business days.

3. **Outreach initiated** – Your organization completed initial outreach within five (5) business days of receiving the member referral from Molina's ECM Team. If this is the case, you will report Outreach initiated in the **Referral Status** question and will add the date your organization conducted initial outreach under the **Date of Referral Status** column. Molina requires a total of five (5) outreach attempts to be completed within sixty (60) calendar days of your organization receiving the member referral, this means a member should not have an Outreach initiated status no more than (60) calendar days. If you have NOT enrolled within (60) calendar days, please proceed with a CLR form and Close Loop on the referral. Report Outreach initiated referral status until you've exhausted all outreach attempts, and the same date you completed initial outreach in the **Date of Referral Status** field. **Note:** Once you indicate Outreach initiated in the CLR Form, you will not be able to change the referral status in future submissions to Pending or Accepted.

4. **Referral Loop Closed** – Your organization has closed-loop on the member referral because of one of the following reasons:
   - Member Enrolled into ECM- member was enrolled in ECM. Enter the ECM Benefit Start Date in the **Date of Referral Status** question.
   - Service Provider Declined-The ECM Provider declined referral due to being at max capacity or is unable to serve member's Population(s) of Focus, or declined due to member being outside their service area, or member presented unsafe behavior or environment for the ECM Provider's staff. Enter the date the ECM Provider declined the member referral in the **Date of Referral Status** field.
   - Unable to Reach Member-The ECM Provider exhausted the (5) minimum required outreach attempts and was not able to enroll the member in ECM because the member was unable to contact (UTC), or the ECM Provider had insufficient contact information to outreach the member, enter the last outreach attempt date or if the ECM Provider has insufficient contact information to outreach the member, enter the date this was identified in the **Date of Referral Status** field.
   - Member No Longer Eligible for Services- The ECM Provider was not able to enroll the member in ECM because the member is no longer eligible for services. Enter the date you identified or was made aware of one of the following close loop referral reasons in the **Date of Referral Status** field.
     o Member is deceased
     o Incarcerated
     o Duplicative program- Programs include CA EAE DSNP Plan, Non-EAE DSNP Plan, CCM, Hospice, etc. ECM Provider must verify if a member changed to CA EAE DSNP plan or Non-EAE DSNP plan by checking Molina's Availity Portal prior to outreach.

- Lost Medi-Cal coverage- ECM Provider must verify this information by checking Availity prior to outreach.
- Switched health plans- ECM Provider may be able to verify if a member is no longer with Molina Healthcare by checking Molina's Availity Portal prior to outreach.
- Moved out of the county
- Moved out of country- ECM Provider may be able to verify if a member is no longer with Molina Healthcare by checking Molina's Availity Portal prior to outreach.
- Member does not qualify for at least one Population of Focus
- Member No Longer Needs Services or Declines Services- The ECM Provider was not able to enroll the member in ECM because the member declined to enroll. Enter the date the member declined to enroll in the ECM Program in the Date of Referral Status field.

Please refer to ECM Provider Manual Part 2 for instructions on how to access and complete the Closed Loop Referral From.

Provider Requirements for CLR

Effective July 2025, ECM Providers are required to provide the *latest* Referral Status (on a monthly basis, by the 25th of the month) for each member they have not closed loop or each member they closed loop *during* the reporting month by completing the **ECM Closed Loop Referral Form**. Refer to the **Referral Status Guide** for referral status descriptions. Note, once you have completed the **ECM Closed Loop Referral Form and you have closed loop (e.g., member has enrolled),** for each member referral, thereafter, please do not complete another **ECM Closed Loop Referral Form.**

ECM Outreach Reporting, Billing and Reimbursement

- ECM Providers should bill ECM Outreach via claims following the normal billing process and using the ECM Outreach code/modifier combination per DHCS Billing/Coding guide.
- Claims can be submitted using the Availity portal or utilizing the ECM Provider's normal claims submission process.
- The reimbursement is a fixed amount per diem, as communicated by the Molina Contracting team. This means that regardless of the number of units billed, the maximum allowable per date of service is equal to the agreed-upon flat rate. ECM Providers can outreach as many times as needed or necessary to enroll a member into the program. However, only a maximum of five (5) attempts are reimbursable per member.
- Reimbursement is only provided for members who are actively enrolled with Molina Medi-Cal for the date of service.
- Reimbursement is NOT provided for members who are assigned and/or receiving ECM services with another provider (refer to Availity for ECM enrollment information).
- For non-MIF members (referrals), the Molina ECM team must receive a referral for the member to be reimbursed for ECM outreach.

This reimbursement is pre-enrollment into ECM. Once the member is enrolled in ECM, the ECM Provider will receive monthly capitation for the member and should not bill any more ECM outreach claims for that member while the member is enrolled in ECM.

MOLINA®
HEALTHCARE

Privacy Breach

ECM Providers are only permitted to outreach, provide ECM services, and look up members in CCA who are assigned to their organization. If ECM Providers are outreaching, providing ECM services, or looking-up members in CCA not assigned to their organization, this is considered a HIPPA privacy breach and will result in further action being taken by the Molina ECM team.

Cultural Competency Trainings/Person-Centered Care Planning Trainings

Cultural Competency Trainings: To ensure the ECM LCM is providing culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice, ECM Providers are required to provide their staff Cultural Competency training. Anyone from the ECM Provider's ECM team who works with our ECM members, especially the member's assigned ECM LCM should receive Cultural Competency Training as they are on-boarded (new staff) and on an annual basis (refresher). The ECM Provider must track attendance of these trainings, as well as training dates. Molina will request attestations from the ECM Provider confirming who was provided these trainings, as well as the actual training provided.

- For LA County providers: If your organization contracts with Health Net and your staff already completed Health Net's Cultural Competency trainings, your staff is not required to receive additional Cultural Competency trainings. However, we will still require attestation that the training was completed.
- For all regions, if you have completed Cultural Competency training with another MCP, we request that you submit a copy of the training to Molina for review to determine that the requirement has been met. Attestation is still required.
- Molina will conduct Cultural Competency training annually for all ECM Providers and their staff.
- If the ECM Provider organization already has Cultural Competency training, please submit a copy of the training to Molina for review to determine that the requirement has been met. Attestation is still required.

Person-Centered Planning Trainings: Per federal requirements, if the member has LTSS needs (identified during completion of the Comprehensive Assessment), the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process, as established in 42 CFR § 438.208 and 42 CFR § 441.301, and should consider and reflect what is important to the member regarding their preferences for the delivery of LTSS (e.g., specific treatment goals, services or functional needs the member prefers to prioritize).
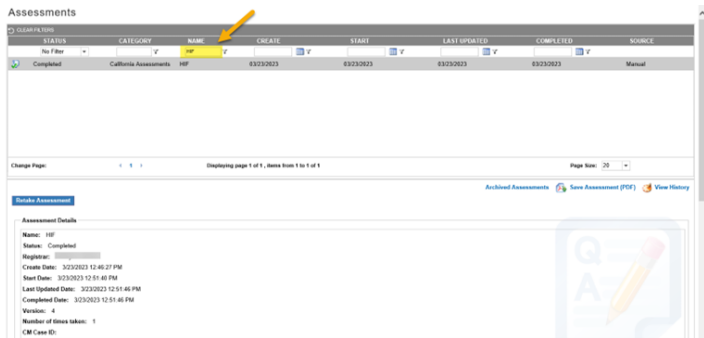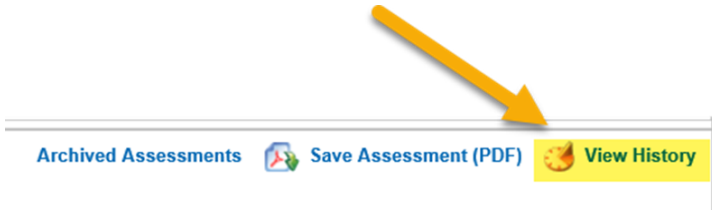
In addition to administering Cultural Competency trainings to their ECM staff, ECM Providers must also provide Person-Centered Planning trainings to all their ECM LCMs as they are on-boarded (new staff) and on an annual basis (refresher). The ECM Provider must track attendance of these trainings, as well as training dates. Molina will request attestations from the ECM Provider confirming who was provided these trainings, as well as the actual training provided.

Molina conducts Person-Centered Planning training for all ECM Providers and their staff. Reach out to Molina's ECM Team for the next training.

MOLINA® HEALTHCARE

Pre-Call Review

The ECM LCM is required to complete a pre-call review **post-enrollment** and document it via a contact form in CCA. This pre-call review exercise includes reviewing the information found in CCA, such as the Member Dashboard, available clinical notes in CCA, as well as reviewing Availity (new Provider Portal) and CCP. The ECM Provider will continue to complete the pre-call review post-enrollment, at a minimum of once a month prior to a member encounter. This is to detect any new patterns of care and will continue to document these reviews via a contact form in CCA. When conducting the pre-call review, the ECM LCM must also review the Assessments module in CCA and search for "**HIF**" under the Name section to see if the member completed a recent **Health Information Form (HIF)**. The ECM LCM is required to **review** the HIF on record for any positive responses and address them with the member no later than **5 business days** from reviewing the "HIF." NOTE: The objective is to review the HIF (if member has a recent one on record), not to complete the HIF with the member. If you note a change in member's condition upon your review and discussion with the member, please complete a new Comprehensive Assessment and update the care plan within 10 business days from reviewing the "HIF" positive responses with the member.

Instructions	Screenshot
Step 1: Search for "**HIF**" in the Assessments module in CCA	
Step 2: Select **View History**	

MOLINA HEALTHCARE

Step 3:

Bring into focus the most recent HIF assessment (if you already addressed the most recent HIF assessment, then note this in the pre-call review contact form) and select **View Report**

STATUS	**REGISTRAR**	**SOURCE**	**CREATE**	**START**	**LAST UPDATED**	**COMPLETED**
Completed		Manual	3/23/2023	3/23/2023	3/23/2023	3/23/2023

HIF Assessment History

View Progress Notes   Go To Assessment List

Archived Assessments   View Report   Download Excel   Download PDF   Download Word   Void Assessment

Assessment Details

Step 4:

The HIF assessment will appear in a separate window.

Reminder: The ECM LCM is to review and address any positive responses with the member. This should all be documented in a contact form(s). If you note a change in member's condition upon your review and discussion with the member, please complete a new Comprehensive Assessment and update the care plan within 10 business days from reviewing the "HIF" positive responses with the member.

HIF Assessment

Member Information

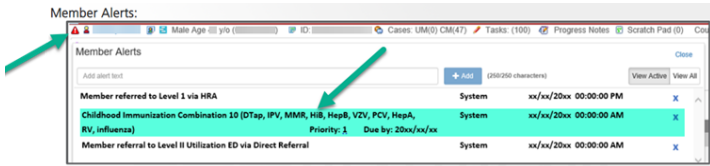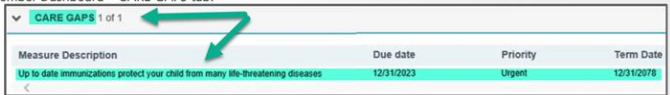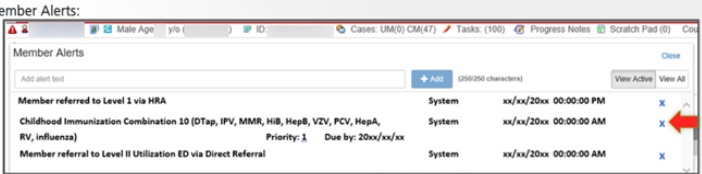| Member Name		Plan	
Medicaid #:		Medicare #:	

HIF Details

Date of HIF Conducted	3/23/2023
Assessment Method	Telephonic
If other, please describe:	
Name of person completing form / assessment (if other than member)	Member
Relationship to member	Member
Do you need to see a doctor within the next 60 days?	Yes
Do you take 3 or more prescription medicines each day?	No
Do you see a doctor regularly for a mental health condition such as depression, bipolar, or schizophrenia?	Yes
Have you been to the emergency room two or more times in the last 12 months?	Yes
Have you been admitted to the hospital in the last 12 months?	Yes
Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last 6 months?	Yes
Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags?	No
Do you have a condition that limits your activities or what you can do?	Yes
Are you pregnant?	No

If yes, are you currently seeing a doctor for this pregnancy?	
Do you see a doctor regularly for a chronic medical condition?	Yes

Medical Conditions

Asthma	Yes
Cancer	No
Cystic Fibrosis	No
Diabetes	No
Heart Problems	No
Hepatitis	No
High Blood Pressure	Yes
HIV or AIDS	No
Kidney Disease	No
Seizures	No
Sickle Cell Anemia	No
Tuberculosis	No
Other	Saw doctor 2 years ago but has not since moving and becoming homeless Chronic Depression, PTSD, Anxiety, OSA, Nightmare disorder

Another requirement is reviewing the **HEDIS/Gaps** in Care in CCA. These HEDIS/Gaps in Care may include immunizations, cancer screenings, flu shots, etc. The ECM LCM is required to review these alerts as part of the pre-call review activity. If the member has a HEDIS/ Gaps in Care alert, the ECM LCM will need to educate the member on the importance of preventative care, discuss details of missing HEDIS/ Gaps in Care measure, and assist member with care coordination to help remove potential barriers. ECM Providers are also receiving a HEDIS/ Gaps in Care Report via the Sftp Site every 1st of the month. The report, CCA alerts, and Care Gaps section in the Member Dashboard should all align, and the ECM LCM can choose which method to review these HEDIS/Gaps in Care.

Follow steps below to view the HEDIS/ Gaps in Care in CCA:

Instructions	Screenshot
The ECM LCM can check for any HEDIS/ Gaps in Care alerts by going into: **Option 1:** The Member Alerts. Click on the red triangle (left-hand corner next to the member's name). Or **Option 2:** The Member Dashboard – CARE GAPS tab: **NOTE:** The ECM LCM is required to follow up with the member on the outcome of the HEDIS/Gap by the due date indicated (See screen shots above). Refer to the Contact Form Scenarios section for documenting this review.	
To close the alert, select the '**X**' to the far right of the alert. **NOTE**: If a claim is received showing evidence that the HEDIS/Gap in Care was completed before you are able to discuss it with the member, the HEDIS/Gap in Care will automatically close.	

ECM LCM Credentials and Confirmation of their Expertise and Skills

The ECM LCM must document their credentials and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate, and person-centered manner post-enrollment via a contact form in CCA within **five business days** from assigning an ECM LCM to the member. If there's a change in the ECM LCM assignment, the new ECM LCM must do the same exercise within **five business days** from the member assignment. If you have not completed this for any of your active enrolled members, please enter this in CCA as soon as possible, this includes HHP and WPC transition members.

Members Aging Out

Youth members approaching age 21 need to be assessed against the Adult Populations of Focus criteria. Molina's ECM Team will send reminders to our ECM Providers once this time approaches. The ECM LCM must discuss the Adult Populations of Focus criteria with the member, document the discussion in a contact form in CCA, note the Adult Population(s) of Focus criteria the member qualifies, and inform Molina's ECM Team. Molina's ECM Team will note the new Adult Populations of Focus in their system. If a youth member does not meet an Adult Populations of Focus criteria, the ECM Provider should apply the graduation criteria to determine when the member is ready to be disenrolled from ECM.

Physician Certification Statements

Per APL 22-008, Health Plans are required to obtain a Physician Certification Statements (PCS) form (*found on Molina's public website under* **Transportation**: molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx demonstrating members need for Non-Emergent Medical Transportation (NEMT). ECM LCM is to reach out to the member's Provider/Facility and request that they complete the authorization request form for NEMT Services. We ask that the ECM LCM make up to three (3) attempts to contact the provider/facility. Both providers must complete the PCS if the member has multiple standing orders. The Provider needs to complete the PCS form and submit the completed form to American Logistics (AL) via fax at (877) 282-8441 or by email at MolinaFax@AmericanLogistics.com.

The ECM LCM will create a contact form in CCA with the subject line "NEMT PCS outreach" and document the outcome of the contact. The ECM LCM needs to elaborate on any other member findings/discussions held with the provider, as applicable (e.g., "Contacted <Provider/Facility>, educated on PCS form for NEMT mode of transportation for the members standing order. The provider reported understanding and agreed to complete and submit the PCS form to AL. Provided the members' Provider with the PCS form"). New guidance: A PCS Form is also needed for ambulatory door-to-door service transportation; refer to the form for more information.

Molina's ECM Team might also come across some members with outstanding PCS Forms and will contact our ECM Providers for support on this matter and request updates.

For Non-Medical Transportation (NMT), a PCS form is not needed. The ECM LCM should indicate in the request to American Logistics when setting up the appointment that it's non-medical.