Enhanced Care Management

Provider Manual

Part 4

(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

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Clinical Consultant Reviews

Each ECM provider is required to have a Clinical Consultant on their care team to oversee the clinical aspects of the program. The Clinical Consultant should review the Comprehensive Assessment, additional assessments, care plan, participate in ICT meetings, and provide input during these discussions. Clinical reviews need to take place on a recurring basis (e.g., when ECM LCM is developing the care plan, or updating the care plan due to the member's change in condition or providing input during ICTs, etc.) and be documented via a contact form in CCA by the Clinical Consultant. The ECM LCM is responsible for coordinating these ICT meetings.

This individual is responsible for the following:

- Ensuring clinical assessment elements leading to the creation of the plan of care are under the direction of an independently licensed clinician.
- Review documentation and provide input as needed.
- Acting as the clinical resource for your team as needed.
- Assist with care coordination for members as needed.

This role must be filled by an independently licensed clinician who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, LVN, advanced practice nurse, nutritionist, licensed behavioral health care professional, social worker, or other licensed behavioral health care professional. The licensure for your clinical consultant must be an active license in good standing in California.

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Clinical Consultant Reviews - Contact Forms

Clinical consultant reviews must be documented via a Contact Form in CCA. The ECM LCM **cannot** document on behalf of the Clinical Consultant. Clinical staff must enter their own documentation, and non-clinical staff must also enter their own documentation because all Encounters are reported to the state and each Encounter must be identified if it was completed by a clinical care manager vs non-clinical manager. Documentation of Clinical Consultant name, credentials, and review and input of the Comprehensive Assessment and ICP (if the ECM LCM holds an appropriate clinical license, no clinical consultant review is required). Each Comprehensive Assessment, assessment, ICP, or ICT meeting must include documentation of the review/input of the Clinical Consultant.

- Contact Type: Interdisciplinary Care Team
- Contact Date: Date clinical review occurred
- Contact Method: Select the appropriate contact method
- Contact Direction: Outbound
- Respondent: ECM Provider
- HIPAA Identity/Authority Verification: Member ID, DOB or Address, DOB or Member ID, Address
- Purpose of Contact: ICT Meeting, ECM, (any other valid service like Care Plan Development/ Revision if discussing care plan)
- The Outcome of Contact: Successful Contact
- Length of Contact: Time it took to complete the clinical review

Include in the contact form notes section the name of the Clinical Consultant who conducted the review, their credentials, and the outcome of the clinical review.

Below is an example of how to complete a Contact Form in CCA:

Scenario #1: Post-enrollment. ECM LCM presented the member's care plan to their Clinical Consultant. The Clinical Consultant reviewed the care plan.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	[Insert name of your Organization - ECM] Clinical Consultant Review 4/10/24
Contact Type	Interdisciplinary Care Team
Contact Date	04/10/2024
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	ECM Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB

Purpose Of Contact	ECM Care Plan Development/ Revision ICT Meeting
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	45
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/10/24, I presented the care plan to our clinical consultant, Nadine Khan, RN. Nadine reviewed the care plan and had no additional feedback to provide. I will meet again with Nadine to discuss the member's progress next month.

Comprehensive Transitional Care

- Transitional Care Services include services intended to support members and their families and/or support networks as members transfer from one setting or level of care to another, including, but not limited to discharges from hospitals, institutions, other acute care facilities, and SNFs to home- or community-based settings, Community Supports, post-acute care facilities, or LTC settings.
- Services include supporting Members' transitions from discharge planning until they have been successfully connected to all needed services and supports.
- Additionally, ECM Providers should provide information to the hospital discharge planners or discharging facility staff about ECM so that collaboration on behalf of the Member can occur in as timely a manner as possible and that the member does not receive two different discharge planning documents.
- Transitional Care Services can help avoid unnecessary readmissions.

Transitional Care Services include, but are not limited to:

- Knowing, in a timely manner, each Member's admission, discharge, or transfer to or from an ED, hospital inpatient facility, SNF, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
- Developing strategies to reduce avoidable member admissions and readmissions. Examples include ensuring timely prior authorizations and discharges, establishing agreements and processes to promptly notify the member's ECM LCM, who will ensure all Transitional Care Services are complete, including but not limited to:
    o Ensuring discharge risk assessment and discharge planning document is created and shared with appropriate parties.
    o Planning timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners.
    o Conducting medication reconciliation or Closed Loop Referrals, developing policies to arrange transportation for transitional care, including to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures.
    o Easing the Member's transition by addressing their understanding of rehabilitation activities, self- management activities and medication management.
- For Members who are experiencing or are likely to experience a care transition, the ECM LCM is responsible for:
    - Developing and regularly updating a discharge planning document for the member; this includes facilitating discharge instructions developed by a hospital discharge planner or discharge facility staff.
    - Ensuring the completion of discharge risk assessment and coordinating any follow up provider appointments and support services to facilitate safe and appropriate transitions from one setting or level of care to another.

- Coordinating medication review/reconciliation.
- Providing adherence support and referral to appropriate services.

For more information about transitional care more broadly (for those in and not in ECM), refer to the PHM Policy Guide, Section E. Providing PHM Program Services and Supports: c. Transitional Care Services

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Transitions of Care

Hospital Census Data

Molina's ECM Team will share hospital census data with ECM Providers electronically via sFTP when a provider has an assigned member who is admitted or discharged from a hospital. The Daily IP Census Report includes MIF and referred members who have not been enrolled and members who have been enrolled and assigned to the ECM Provider. ECM Providers are encouraged to use this report to outreach members in the hospital or SNF for enrollment into the ECM Program. ECM Providers may also be able to learn about hospital admissions before Molina; therefore, ECM Providers must use all tools at their disposal to identify and interact with recently admitted/discharged members. ECM Providers must not rely solely on the census from Molina. ECM Providers must use hospital census data to identify ECM members who have been hospitalized and then complete the following activities:

- Follow up with the member via telephone within **two business days** of discharge (or agreed upon date if contact is made with the member before discharge) to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist. Outreach should include interventions to ensure follow-up needs are met.
- ECM provider must reach out to members within **seven business days** of discharge to determine the member's post-inpatient status and any further care needs and complete the Transition of Care assessment. Best practice is to conduct a face-to-face visit.
- If the member is unreachable after being admitted and/or discharged, make sure to document all outreach attempts, both successful and unsuccessful, in a Progress Note and clearly specify the TOC Outreach in the subject line.
- ECM LCMs are expected to collaborate, communicate, and coordinate with all parties involved.
- The care plan should be updated post-discharge to address hospitalization and measures to prevent readmission for enrolled members.
- Updated ECM ICP should be shared with the member, PCP, and any parties involved in the patient's care within 14 days of the updated care plan date for enrolled members.
- For enrolled members, evidence of coordination of all services for members during and post-care transitions from lower acuity facilities/departments (emergency departments, skilled nursing facilities, residential/treatment centers, incarceration facilities, etc. For Homeless members, the ECM Providers should plan an appropriate place for the member to stay post-discharge from the hospital or SNF, including temporary or permanent housing, and explore Community Supports referrals.

Follow the steps below to complete the Enterprise TOC assessment in CCA:

INSTRUCTIONS	SCREENSHOT
Step 1: Complete the *Enterprise ToC Assessment*. How do I access the Enterprise TOC Assessment? 1. Open CCA. 2. Search for your member and make sure the member is in focus. 3. Click on Assessments 4. Search for "Enterprise TOC" under *Name* and locate the "Enterprise TOC." 5. Click "Take Assessment."	
• The asterisk indicates mandatory questions. Complete questions in the "**General Information**" section. • The ToC Assessment has built-in branching logic. • You will frequently see the option "Other," which will populate a text box. It is recommended you answer using other options besides the "other" option and expand on your conversation within the documentation.	

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INSTRUCTIONS	SCREENSHOT
Step 2: Next, complete the **Medication Self-Management** section of the TOC Assessment:	

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INSTRUCTIONS	SCREENSHOT
Step 3: **Medication List** • Add the member's medication by clicking Quick Add. • Enter the medication's information. Click Save or Save and Add Another (to add more medications). • A list of Medications will populate. Select Continue Assessment once all medications have been entered.	

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INSTRUCTIONS	SCREENSHOT
Step 4: Next, complete the **Knowledge of Triggers/Red Flags** section of the TOC Assessment: Here we are assessing member's understanding of the BH/ Physical Health related signs and symptoms of their condition and what to do when symptoms get worse/what to do in a crisis Documentation will support members' understanding of their triggers/emergency plans and evidence of self-management education. Responses to specific questions will prompt an ECM Care Plan goal to be auto generated for placement in the Care Plan.	
Step 5: Next, complete the **Appointment** section of the TOC Assessment: Documentation will support the appointment date. Suppose the member does not have a scheduled appointment. In that case, documentation will support education on the importance of the follow-up appointment and encouragement/ assistance in securing and following through with the appointment. If the member states they need other appointments, documentation will support the need and why the member is stating they need this appointment. This documentation will be supported with the ECM Lead Care Manager interventions to act on that need.	
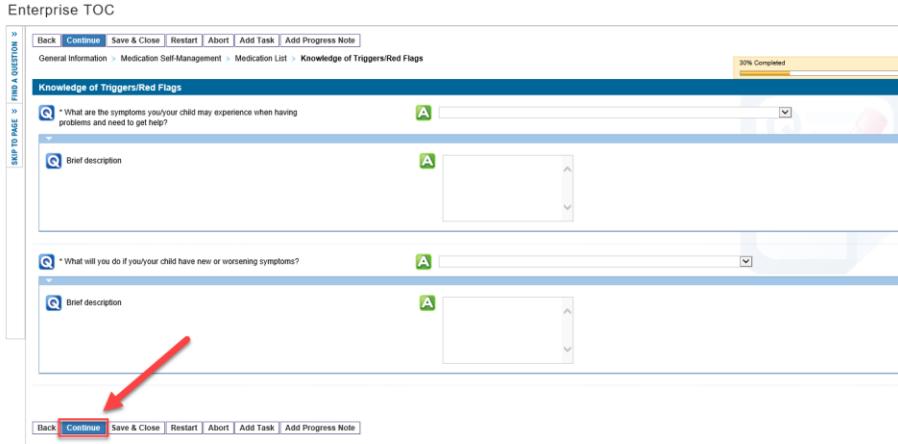
INSTRUCTIONS	SCREENSHOT
	If Yes, already saw the doctor since being discharged, fill-out branching questions:
Step 6: Next, complete the **Social Determinants of Health** section of the TOC Assessment: If the member does not have access to food, documentation should support the ECM Lead Care Manager's interventions to assist the member in identifying a food resource. If the member identifies support needs here, documentation should support the discussion of support systems and resources available.	
Step 7: Next, complete the **Dietary and Nutrition Needs** section of the TOC Assessment: If member identifies they have special diet instructions, documentation should support member's understanding of these restrictions and ECM Lead Care Manager education to support the specific diet.	
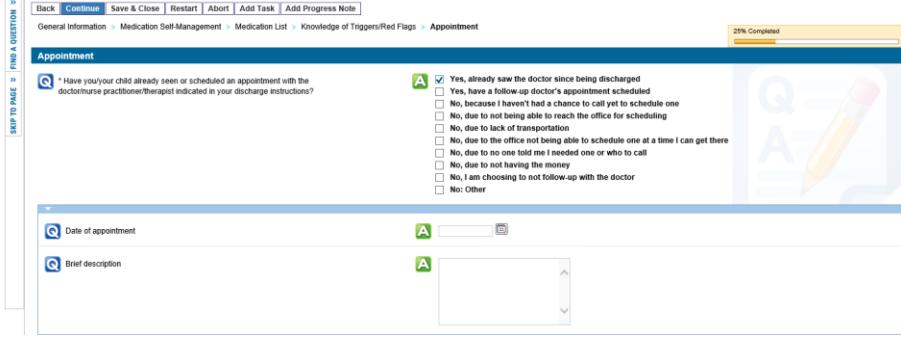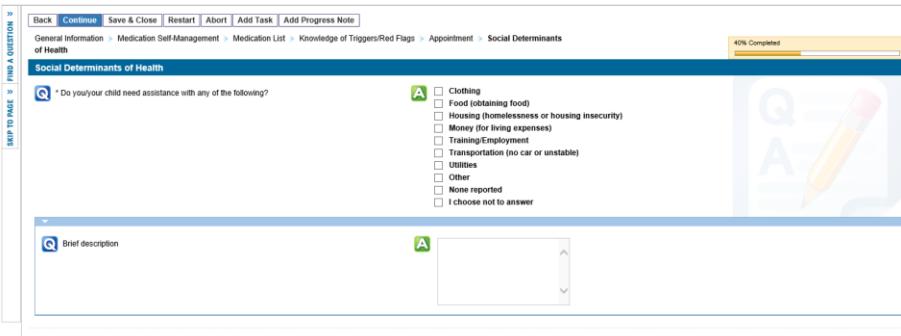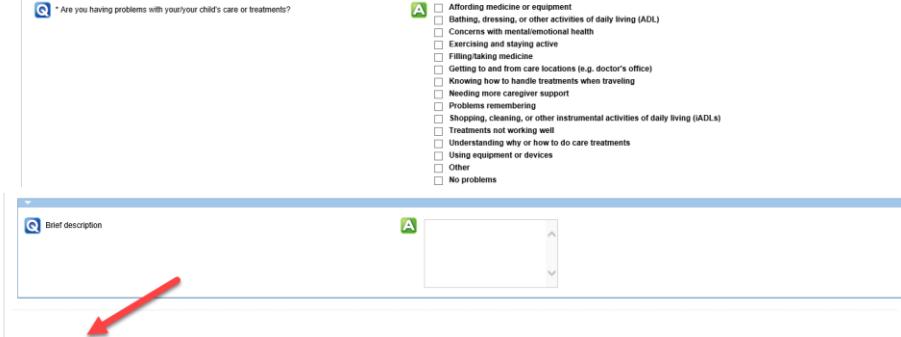
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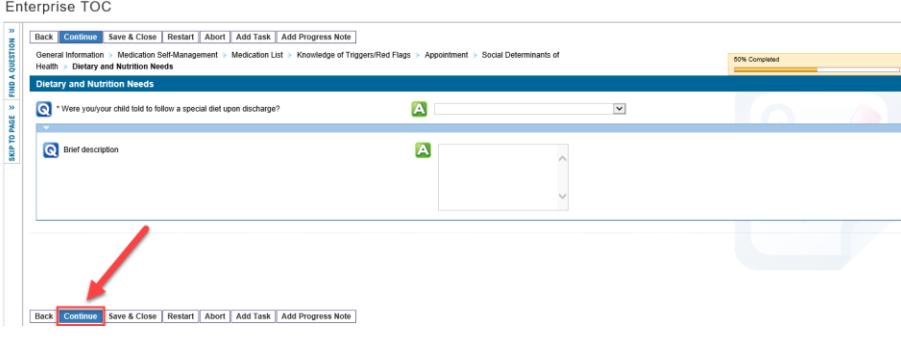
INSTRUCTIONS	SCREENSHOT
Step 8: Next, complete the **Home Health and Durable Medical Equipment** section of the TOC Assessment: Documentation will support the member's identified need and why this is a need. Documentation should also support the ECM Lead Care Manager in addressing this need through education and/or assistance in obtaining the DME.	
Step 9: Next, complete the **Personal Health Journal** section of the TOC Assessment:	

INSTRUCTIONS	SCREENSHOT
You have now completed the TOC Assessment. Click Continue. The ECM Care Plan must be updated with any new coordination of care needs. Please see the **ECM Care Plan** section below for further guidance on this.	Enterprise TOC Back	Continue General Information › Medication Self-Management › Medication List › Knowledge of Triggers/Red Flags › Appointment › Social Determinants of Health › Dietary and Nutrition Needs › Home Health and Durable Medical Equipment › Personal Health Journal › **Final Page** **Final Page** 100% Completed View Report Back	Continue
ECM Care Plan (refer to Care Plan section for more information) The ECM Care Plan must be updated with any new coordination of care needs. Select the ECM Care Plan in CCA and edit (under Case Options). Assessment responses will potentially generate recommended guidelines to apply to the member's ECM Care Plan goals. Select any applicable guidelines for incorporation into the member's Care Plan.	Member Cases & Tasks Cases	Tasks New Case ▾	Case Options ▾	More Options ▾ ⟳ MANAGE MY FILTERS	⊞ ADD/REMOVE COLUMNS	🖶 PRINT	↺ CLEAR FILTERS |	Case Setting	Case Name	Case ID	Status
---	---	---	---	---
	No Filter ▾	▽	▽	No Filte
▸ 📁		ECM - Diabetes	CM9436038	Open	
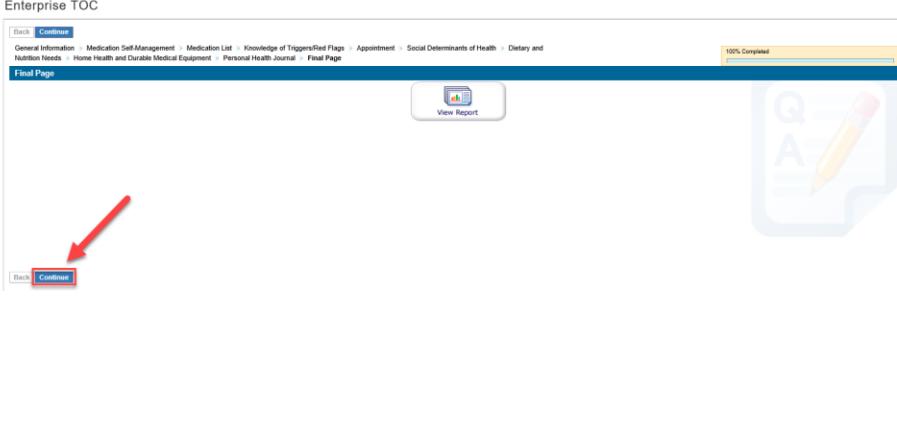
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Transitions of Care - Contact Forms

All activities involving Transitions of Care are required to be documented via a Contact Form in CCA; this includes evidence of coordination of all services for members during and post-care transitions from lower acuity facilities/departments (emergency departments, skilled nursing facilities, residential/treatment centers, incarceration facilities, etc.

Below is an example of how to complete a Contact Form in CCA:

Scenario #1: Post-enrollment. The member was discharged from the hospital. ECM Provider completed the Transitions of Care Assessment with the member within seven business days of discharge, new Comprehensive Assessment, and updated care plan since there was a change in condition. Checked in with member and informed member he's working on coordinating doctor appointments.

Contact Form Fields	How to Complete Contact Form Fields
Subject	ECM Program - [Insert name of your Organization - ECM] TOC Assessment Completion 6/1/24
Member First Name	John
Member Last Name	Smith
Contact Type	General Contact
Contact Date	06/01/2024
Contact Method	Face to Face - Home
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Post Discharge Outreach Assessment Care Plan Development/ Revision Coordination of Services
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	60
Name of Provider	
Adult Day Healthcare	

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Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 6/1/24, I conducted an in-person visit to the member's home. Member has been feeling better since leaving the hospital; however, experiencing very little pain. I completed the Transitions of Care Assessment, a new Comprehensive Assessment, and updated the care plan since there was a change in condition. Member consented to care plan. I will also coordinate follow-up doctor appointments on behalf of the member.

Referrals

ECM Providers are required to make referrals to appropriate services/programs depending on their assigned member needs. These referrals need to be clearly documented via the Contact Form in CCA to evidence that follow-up on referrals was made, member needs were met, and care gaps were closed.

Palliative Care Referrals

The ECM process for referring Molina Members to our "My Care" Palliative Care program involves two options:

- **Request via PCP**: Send a request to the member's PCP to review if the member is appropriate for palliative care. If the PCP believes that the member is appropriate, the PCP office will then send a palliative care authorization request to us.
- **Direct Referral**: Send a referral directly to one of our contracted My Care providers. They will review if the member meets palliative care criteria and, if so, send an authorization request to Molina.

*Please see the appendix for Molina Contracted My Care (Palliative Care) Program Preferred Provider List.

Coordination of and Referral to Community and Social Support Services

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed. Coordination of and Referral to Community and Social Support Services could include, but are not limited to:

- Determining appropriate services to meet the needs of members, including services that address SDOH needs, including housing, and services offered by Molina as Community Supports.
- Coordinating and referring members to available community resources and following up with members (and/or parent, caregiver, guardian) to ensure services were rendered (i.e., "closed-loop referrals").

Referrals to Community Support Services

ECM Providers are expected to refer members to Community Support services as applicable. For example, suppose a member is in the "Members Experiencing Homelessness" Population of Focus. In that case, the ECM LCM needs to complete a *Community Supports Housing Services Referral* (*Reminder: contact forms need to reflect that the member was referred to CS Housing Services*). Below is a complete list of the Community Support services that Molina offers. Molina's CS Team will host a separate training to discuss these Community Support services and review their process.

- The ECM LCM must document in CCA evidence that the member was referred to a Community Support service, indicate which Community Support service the member was referred, and show it was a closed-loop referral.
- Molina's CS Team will host a separate training to discuss the different Community Support services that we offer and review their CS process.
- Molina's CS Referral Forms are located on Molina's website and lists all the CS services that are offered by our plan: molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

Community Supports	Los Angeles	Riverside	Sacramento	San Bernardino	San Diego
Housing Transition Navigation Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Deposits	7/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Tenancy and Sustaining Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022

Community Supports	Los Angeles	Riverside	Sacramento	San Bernardino	San Diego
Short-Term Post-Hospitalization	1/1/2024	7/1/2022	7/1/2022	7/1/2022	1/1/2024
Recuperative Care (Medical Respite)	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Respite Services	1/1/2024	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Day Habilitation Programs	1/1/2024	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities	1/1/2024	1/1/2024	1/1/2024	1/1/2024	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	1/1/2024	1/1/2022	1/1/2024	1/1/2022	1/1/2022
Personal Care and Homemaker Services	1/1/2024	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Environmental Accessibility Adaptations (Home Modifications)	7/1/2022	1/1/2024	7/1/2024	1/1/2024	7/1/2024
Medically Tailored Meals/Medically-Support Food	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Sobering Centers	1/1/2022	1/1/2022	1/1/2022	1/1/2026	1/1/2022
Asthma Remediation	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Transitional Rent	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026

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Please fax CS referrals to (800) 811-4804. If you need additional support or have CS related questions, please contact the CS team at MHC_CS@molinahealthcare.com.

Referral Forms
- CS Short-Term Post-Hospitalization Housing Referral Form
- CS Respite Services – Home Referral Form
- CS Day Habilitation Programs Referral Form
- CS Recuperative Care Referral Form
- CS Personal Care and Homemaker Services Referral Form
- CS Medically Tailored Meals Referral Form
- CS Housing Transition Navigation Referral Form
- CS Housing Tenancy and Sustaining Referral Form
- CS Housing Deposits Referral Form
- CS Community Transition Services Referral Form
- CS Asthma Remediation Referral Form
- CS Environmental Accessibility Adaptations – Home Modification Referral Form
- CS Environmental Accessibility Adaptations – Home Modification Physician Form
- CS Transition to Assisted Living Facilities or Residential Care Facilities Referral Form
- Pregnancy Referral Form
- Care Management Referral form
- Enhanced Care Management Member Referral Form
- Community Health Worker Referral Form
- Housing Specialist Referral Form
- Dental Coordination Referral Form

Referrals to Social Support Services

Adult members can be enrolled in ECM and Community-Based Adults (CBAS). ECM enhances and/or coordinates across the case/care management available in CBAS centers. The ECM LCM must ensure non- duplication of services between ECM and CBAS centers.

- CBAS and ECM services are complementary.
- ECM can offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center.

Community-Based Adult Services (CBAS) and In-Home Support Services (IHSS)

In addition to referring members to Community Support Services, the assigned ECM LCM should refer adult members to Community-Based Adults (CBAS) and In-Home Support Services (IHSS), as applicable. The grids below outline the steps on how to refer members:

All Regions		
	Community-Based Adult Services (CBAS)	**In-Home Support Services (IHSS)**
Description of Program	• A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health conditions and/or disabilities at risk of needing institutional care. • The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. It also provides a respite solution for caregivers.	• Helps pay for in-home services such as personal care and homemaking. • The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care. • The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services • Transportation to and from the CBAS center to your home	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)
Who is Eligible?	• To be eligible, the member must meet one of the following diagnostic categories:	To be eligible, the member must: • Be 65 years of age OR disabled OR blind. • Also, be a California resident. • Have a Medi-Cal eligibility determination.

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	• Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness. • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia) • Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services. • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL listed above, along with money management, accessing resources, meal preparation or transportation. Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours.	• Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help. Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.
Process	• An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). • If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. • The ICT should collaborate and develop/update the care plan.	• A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. • Based on the need for assistance with ADLs /IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. • If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. • The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process	**Standard referral:**	**Standard referral process:**

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- The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. - Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Los Angeles County** - Submit Los Angeles County IHSS Referral Form to Molina through the Molina CA LTSS mailbox at: CALTSS@molinahealthcare.com. **Riverside County** - Contact the Department of Public Social Services (DPSS) to initiate an IHSS referral. Web Referral: riversideihss.org/Home/IHSSApply - After a referral is made, download the referral and email it to the LTSS mailbox at CALTSS@molinahealthcare.com, for tracking purposes. **San Bernardino County** - Submit the county IHSS Referral form to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. **Sacramento County** Contact Sacramento County In-Home Support Services directly: Phone: (916) 874-9471 **San Diego County:** Contact Aging and Independence Services (AIS) to initiate an IHSS referral: Phone: (800) 339-4661 Web Referral: Register and complete referrals aiswebreferral.org/Account/Login.aspx?ReturnUrl=%2f **Los Angeles County Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist the member in contacting IHSS Helpline: (888) 822-9622. **Riverside County & San Bernardino County Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Submit an email to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. Flag referral as redetermination and provide justification. **Sacramento Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member to contact Sacramento County IHSS: (916) 874-9471 **San Diego Redeterminations:** Members may be eligible for a redetermination of hours if the

		member has experienced a significate change in functional ability. Assist member by contacting AIS: (800) 339-4661
		Los Angeles County Public Authority- Assist the member by contacting the Personal Assistance Service Council (PASC): (877) 565-4477
		Riverside County & San Bernardino County Public Authority: Submit an email to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com.
		Sacramento County Public Authority: Assist member by contacting the Sacramento County IHSS Public Authority: (916) 874-2888
		San Diego County Public Authority- Assist the member by contacting the San Diego IHSS Public Authority: (866) 351-7722
Document Referral	• When a referral for CBAS is made, document referral in your EHR system. • Document when the member is initially assessed and/or when referred to a resource.	• When a referral for IHSS is made, document referral in your EHR system. • Document when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): aging.ca.gov/Providers_and_Partners/ Community-Based_Adult_Services/ CBAS_Providers/	**Riverside County:** • IHSS: (888) 960-4477 • Public Authority: (888) 960-4477 **San Bernardino County:** • IHSS: (877) 800-4544 • Public Authority: (866) 985-6322 **Los Angeles County:** • IHSS: (888) 944-4477 • IHSS Helpline: (888) 822-9622 • Public Authority: (877) 565-4477 **Sacramento County:** • IHSS: (916) 874-9471 • Public Authority: (916) 874-2888 **San Diego County** • IHSS: (800) 339-4661 • Public Authority: (866) 351-7722

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Disenrolling Members from ECM

If an enrolled member needs to be disenrolled from ECM, the ECM LCM must complete the Disenrollment Form in CCA. If a disenrollment form is submitted but there has not been any CCA documentation, the ECM Provider should not expect payment for the months when no ECM services were documented. If we see no outreaches conducted for a member 60 days of member assignment in CCA, the ECM Molina team will be re-assigning the member to another ECM provider.

If the member is not enrolled and currently in the outreach phase, and the member is UTC or does not want to participate in ECM, please refer to the Closed Loop Referral Form section for more information in part 2. Please note that a Disenrollment Form should not be completed for members not enrolled in the program.

Below is the complete list of disenrollment reasons:

- **The Member has met all care plan goals** = Member's conditions are well-managed, and goals have been met. No additional problems have been identified; therefore, ECM services are no longer needed, and the member is ready to graduate from the program.
- **The Member is ready to transition to a lower level of care** = Member is ready to be downgraded to a lower level of care management. Complete a direct referral to Molina's CM prior to disenrolling member from ECM.
- **The Member no longer wishes to receive ECM** = Member does not want to be in the program currently or is unwilling to engage. This can include instances when a member's behavior or environment is unsafe for the ECM Provider.
- **The ECM provider has been unable to connect with the member after multiple attempts** = Member is unable to be contacted. Also, if you are made aware that a member will be out of the state/country for longer than 30 days, the member needs to be disenrolled from ECM immediately (do not delay disenrolling the member). However, if you are informed that the member is out of the state/country and don't know the member's return date, wait 30 days from the date of identification, and if the member continues to be out of the state/country past the 30 days, proceed with disenrolling the member.
- **Incarcerated** = Member has been incarcerated.
- **Declined to Participate**
- **Enrolled in a duplicative program** = Some ECM-eligible members may be receiving services from another DHCS-approved program. In some cases, the member may choose to enroll in the ECM, and in some cases, they cannot enroll at all. For a complete list of Duplicative Programs, see the latest ECM Policy Guide. Please note that Molina does not consider MedZed HC 2.0, My Palliative Care, & Major Organ Transplant duplicative programs; ECM members can be enrolled in these programs if services are not duplicative.
- **Lost Medi-Cal coverage** = The member is no longer eligible for Medi-Cal benefits through Molina Healthcare.
- **Switched Health Plans** = member switched health plans.
- **Member moved out of the county** = member no longer resides in the county.

- **Member moved out of the country** = member no longer resides in the country.
- **Unsafe behavior or environment** = no longer a safe environment for the ECM LCM.
- **Member not reauthorized for ECM services**
- **Deceased** = The member has expired.
- **Other**

Members' disenrollment can be voluntary or involuntary. If disenrolling the member involuntarily, attempts must be made to notify the member, documented via a contact form in CCA, and all required correspondence mailed prior to disenrolling the member. If the ECM LCM is unable to mail the Post Opt-In UTC Letter or Post Opt-In Decline Letter to a member due to no address on record or wrong address, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form. If a member no longer wishes to be in the ECM Program, the ECM LCM must use the date of discussion as the date of disenrollment in the Disenrollment Form. The ECM LCM must follow the outreach attempts and guidelines outlined in the *Contact Forms & Attempts* section above.

The ECM LCM do the following before completing the Disenrollment Form:

1. **Must close the care plan and open milestones**
2. **Close/resolve all pending tasks**
3. **Remove ECM LCM from the Assignments section in CCA**
4. **Remove ECM LCM from the Address Book**

We defer to our ECM Providers to apply their own judgment to determine if a member should continue with ECM, downgraded to a lower level of care (Molina CM), or graduated completely from the ECM program. Our ECM providers can determine this through monitoring the member's care plan goals and the completion of the Program Completion Questionnaire.

Follow the steps below to disenroll a member from our ECM Program:

Instructions	Screenshot
1. Select the Progress Notes Icon from the Vertical Menu Bar	
2. Select "Add Progress Note" to access the templates for ECM.	
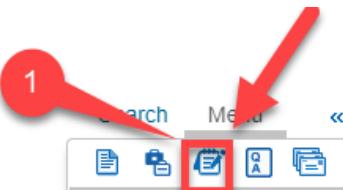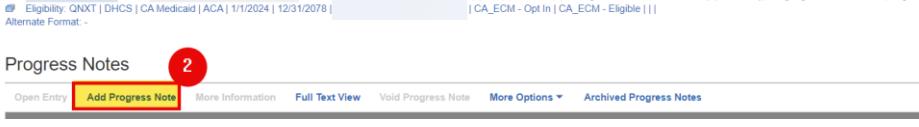
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3. Use the magnifying glass to see the categories of progress notes.

Progress Notes

| Open Entry | Back to Progress Notes | More Information | Full Text View | Void Progress Note | More Options ▾ | Archived Progress Notes |

⌃ Hide Additional Fields

Subject: _____

Security: Level 4 ▾   Category: <Select> ▾

Select Template: [_____] 🔍   Case: [_____] 🔍   Attachments: **Choose Files**

☐ This is a member interaction *(Checking this box ... how additional fields)*

3

Font ▾ Size ▾ Color ▾   **B** ... ≡ ≡ ≡ ≡ | ≔ ≔ ≔ ≔ | ✂ ⎘ ⎘ 🖨

Next, from the list (A), expand the "Member Contact Records – Molina" group,

SELECT TEMPLATE

⊞ **EXPAND ALL**

⊞ Community Resource Referral
⊞ General Forms - Molina
⊞ IA Contact form/Progress Category Folder
⊞ LTSS
⊞ MA Forms
⊞ Medicare
⊞ Member Contact Records - Molina   **A**
⊞ MMP Forms
⊞ New Mexico Forms
⊞ Special Program Forms - Molina
⊞ Texas Forms

Then (B) highlight the ECM Disenrollment form and click "Select."

B **SELECT** **CANCEL**

SELECT TEMPLATE

⊞ **EXPAND ALL**
⊞ MA Forms
⊞ Medicare
⊟ Member Contact Records - Molina
   Auto Dialer Call Attempt
   Care Plan with Consent
   CHW Disenrollment Form
   Contact Form
   Declination of Case Management
   ECM Disenrollment Form
   HROB Contact Form
   Member Texting Consent
   MI MMP Member Contact Record

B **SELECT** **CANCEL**

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|	
4. The disenrollment form will now display. Subject, Security, and Select Template fields will auto-populate.	**Progress Notes** Open Entry · **Back to Progress Notes** · More Information · **Full Text View** · **More Options ▾** · **Archived Progress Notes** ⌃ Hide Additional Fields **Subject:** ECM Disenrollment Form **Security:** Level 4 **Category:** \<Select\> **File:** Browse... **Select Template:** ECM Disenrollment Form **Case:** CM9436038 - ECM - Diabetes ☐ **This is a member interaction** *(Checking this box will show additional fields)* Font · Size · Color · **B** *I* <u>U</u> · align · lists **Enhanced Care Management (ECM) Disenrollment Form** Member Name ＿＿＿ * ＿＿＿ * Member Date of Birth ＿＿＿ 📅 * Medicaid ID ＿＿＿ * Date of Disenrollment ＿＿＿ 📅 * **ECM Disenrollment Reason** * ○ All care goals are met ○ Member is ready to transition to a lower level of care ○ Member no longer wishes to receive ECM ○ ECM Provider has been unable to connect with the member after multiple attempts ○ Incarcerated ○ Member is enrolled in a duplicative program ○ Not enrolled with Molina Medi-Cal Program ○ Switched health plans ○ Moved out of the county ○ Moved out of the country ○ Unsafe behavior or environment ○ Member passed away ○ Member does not meet any ECM PoF eligibility criteria ECM Disenrollment Reason Additional Information Disenrollment reasons are to be documented based on conversation with ECM provider to obtain details of disenrollment information, indicate the date that the member was notified. (All members must be verbally informed whenever possible of the discharge reason prior to submitting Disenrollment form).
In the Enhanced Care Management (ECM) Disenrollment Form, use the calendar picker to select the disenrollment date for the member. Ensure that the member reflects as an "ECM Opt-in" member per the CCA banner. Do not complete the form if there is no indication of opt-in. Choose the ECM Disenrollment	**MOLINA** HEALTHCARE STOP! Before completing this form, verify the CCA banner indicates "ECM Opt-In." If there is no opt-in, do not complete the disenrollment form. **Enhanced Care Management (ECM) Disenrollment Form** Member Name ＿＿＿ * ＿＿＿ * Member Date of Birth ＿＿＿ 📅 * Medicaid ID ＿＿＿ * Date of Disenrollment 8/15/2024 📅 * **4** **ECM Disenrollment Reason** **A** ○ All care goals are met ○ Member is ready to transition to a lower level of care ● Member no longer wishes to receive ECM ○ ECM Provider has been unable to connect with the member after multiple attempts ○ Incarcerated ○ Member is enrolled in a duplicative program ○ Not enrolled with Molina Medi-Cal Program ○ Switched health plans ○ Moved out of the county ○ Moved out of the country ○ Unsafe behavior or environment ○ Member passed away ○ Member does not meet any ECM PoF eligibility criteria ECM Disenrollment Reason Additional Information The member is not interested in the program at this time and refuses further contact. **B** Disenrollment reasons are to be documented based on conversation with ECM provider to obtain details of disenrollment information, indicate the date that the member was notified. (All members must be verbally informed whenever possible of the discharge reason prior to submitting Disenrollment form).

Reason. (See above for full list of 15 Disenrollment Reasons)	
5. After the form is completed, click save. The screen will then populate with all the member's progress notes, and the Disenrollment Form will be the most recent note. The disenrollment form will automatically route to the Molina ECM Team for processing.	Disenrollment reasons are to be documented based on conversation with ECM provider to obtain details of disenrollment information, indicate the date that the member was notified. (All members must be verbally informed whenever possible of the discharge reason prior to submitting Disenrollment form). **5** Save Spell Check Clear Content Cancel

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Direct Referral to Molina's Case Management

For members that need to be downgraded to a lower level of care, the ECM LCM is required to submit a direct referral to Molina's Case Management. Follow the steps below to submit the referral in CCA:

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: 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	
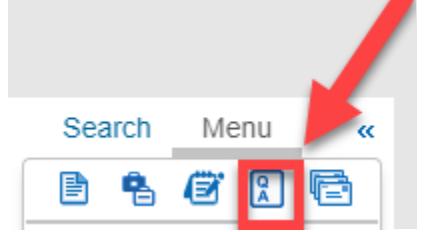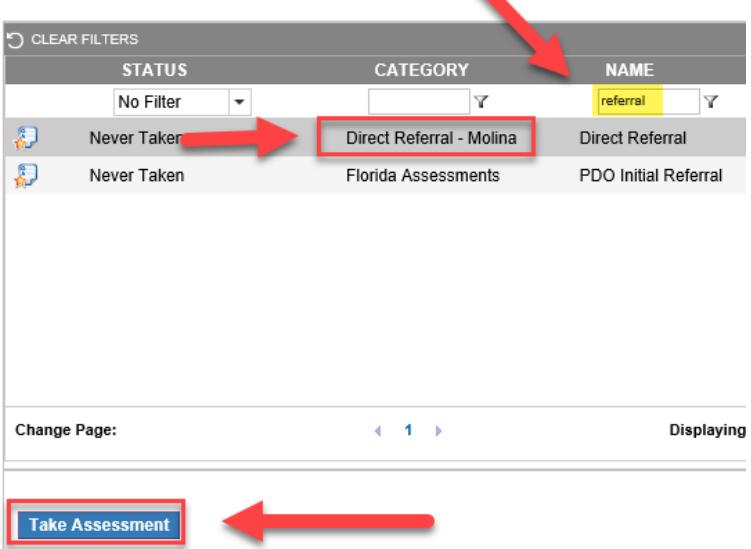
MOLINA HEALTHCARE
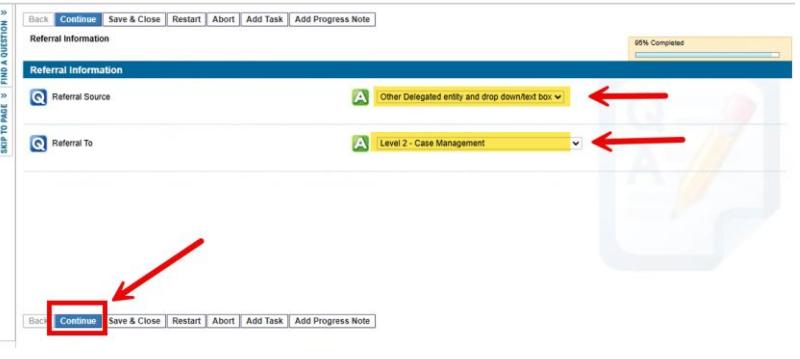
Step 4: Fill out as shown: Click Continue	Direct Referral Back | Continue | Save & Close | Restart | Abort | Add Task | Add Progress Note Referral Information > **Level 2- Case Management** 97% Completed **Level 2- Case Management** * Please select an option below Referral Reason Step Down Comments Document reason why member is being referred to Molina CM Back | Continue | Save & Close | Restart | Abort | Add Task | Add Progress Note
Step 5: The referral to Molina's CM has been submitted. Click **Continue** Please ensure you also complete an ECM Disenrollment form and indicate the reason for disenrollment: *Member is ready to transition to a lower level of care*	**Final** *Congratulations!* You have completed the Health Risk Assessment. Click **View Report** to view your Health Risk Assesment Report. Thank you for taking this active role in your health management. View Report Back | Continue

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Referrals to Community Health Worker (CHW)

CHW is a program that helps improve health outcomes for individuals who experience systemic barriers to care caused by geographic location, language and literacy, and other Social Determinants of Health (SDOH).

If the member decides to decline ECM services, and enroll in CHW or if the member is already enrolled in ECM, but would like to enroll in CHW instead, please submit a CHW referral form and send it to CA_SDOH_Connectors@molinahealthcare.com and please remember to copy our ECM team and include MHC_ECM@molinahealthcare.com.

Please note that the CHW is considered a duplicative program, and the members cannot be enrolled in both ECM and CHW.

The referral form can be found on Molina's website.

Frequently Used Forms (molinahealthcare.com)

Referral Forms
- CS Short-Term Post-Hospitalization Housing Referral Form
- CS Respite Services – Home Referral Form
- CS Day Habilitation Programs Referral Form
- CS Recuperative Care Referral Form
- CS Personal Care and Homemaker Services Referral Form
- CS Medically Tailored Meals Referral Form
- CS Housing Transition Navigation Referral Form
- CS Housing Tenancy and Sustaining Referral Form
- CS Housing Deposits Referral Form
- CS Community Transition Services Referral Form
- CS Asthma Remediation Referral Form
- CS Environmental Accessibility Adaptations – Home Modification Referral Form
- CS Environmental Accessibility Adaptations – Home Modification Physician Form
- CS Transition to Assisted Living Facilities or Residential Care Facilities Referral Form
- Pregnancy Referral Form
- Care Management Referral form
- Enhanced Care Management Member Referral Form
- Community Health Worker Referral Form
- Housing Specialist Referral Form
- Dental Coordination Referral Form
- Doula Services Referral Form

ECM Checklists

The checklists below are provided to assist ECM Providers with the various ECM processes. The checklists provide an overall process flow including the MIF Process, Referral Process, Enrollment Process, Grievance Process, and Disenrollment Process. Please note these checklists do not encompass every single scenario possible and/or additional steps needed. Refer to the ECM Provider Manual for more information on ECM Program requirements:

MIF/Referral Process Checklist
MIF & Referral Notification Process
☐ ECM Provider provides member assignment parameters to Molina ECM Team, as well as any member assignment parameter changes.
☐ **MIF**: Molina's ECM Team sends a monthly MIF to the ECM provider via sFTP.
☐ **Referral**: Molina processes referral form and assigns appropriate ECM Provider. ECM Provider receives secure email notification of assigned member referral.
☐ ECM Provider completes a Closed Loop Referral Form with a status of **Pending** if you have ***not accepted*** the MIF or Referral and you have not started Outreaching the member ***or***
☐ ECM Provider completes a Closed Loop Referral Form with a status of **Accepted** if you have not started outreaching, but plan to conduct outreach.
ECM Provider reviews MIF or Member Referral and informs Molina's ECM Team within five business days:
☐ If there are any discrepancies with the MIF or member referral assignment.
☐ If they are unable to take on any members and need Molina's ECM Team to reassign the members within **5** business days to another ECM Provider
☐ ECM Provider completes a Closed Loop Referral Form with a status of **Referral Loop Closed: Service Provider Declined (Discontinuation Reason Code: 12 or 15)**
Outreach & Engagement Process
☐ ECM LCM will outreach the members in their MIF **within five business days** from the date of receipt of the MIF **or** referred member within five **business days from the date of receipt of the MIF or referral notification and complete the minimum required outreaches within sixty (60) calendar days**
☐ ECM LCM checks Availity before outreaching members from their MIF or referred member to ensure their members are still eligible with our Plan, continues to be a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM **status**.
☐ ECM LCM documents that Availity was checked by entering a Contact Form in CCA. *Purpose of Contact: ECM|Welcome.*
☐ If 1st outreach was successful and the member was enrolled into ECM, refer to the next steps in the *"Enrollment Process Checklist."* A contact form should also be entered in CCA, to evidence completion of the Enrollment Assessment.
☐ ECM Provider completes a Closed Loop Referral Form with a status of **Outreach Initiated.**

MIF/Referral Process Checklist

Member is UTC & Insufficient Contact Information

☐ ECM Provider conducts initial outreach, and member is UTC or ECM Provider does not have sufficient contact information to outreach member.

☐ ECM LCM will complete at least four non-mail attempts and mail the *ECM Generic UTC Letter* (for a total of five attempts within **(60) days**). The outreaches should utilize different modes of contact at different times of the day.

☐ If the ECM LCM has insufficient member contact information, the ECM LCM will complete a direct referral to Molina's Member Location Unit (MLU). The MLU will inform the ECM Provider via a CCA task within fourteen business days if they find alternate contact information. Also, ECM Provider reviews the Daily IP Census Report to outreaches members in the hospital or **SNF.**

☐ ECM LCM documents all UTC outreaches by entering a Contact Form(s) in CCA. **Purpose of Contact = ECM| Welcome Contact. The Outcome of Contact = Left Message, or Disconnected, Invalid Phone #, No Answer, Requested Later Contact**

☐ If, after exhausting the minimum required attempts, the member continues to be UTC, ECM LCM will complete a Closed Loop Referral Form in CCA to Close Loop due to the member being UTC.

☐ A Closed Loop Referral Form in CCA to Close Loop due to the member being UTC. ECM Provider bills ECM outreaches via claims and is reimbursed.

☐ ECM Provider completes a Closed Loop Referral Form with a status of **Referral Loop Closed: Unable to Reach the Member (Discontinuation Reason Code: 4)**

Member Incarcerated

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider is informed that the member is incarcerated.

☐ ECM Provider discontinues further outreach and documents creates a contact form in CCA and state that the member is **Incarcerated, who they spoke to or how they were made aware, and date/time outreach was made.**

☐ ECM Provider documents all outreach attempts as progress notes in CCA.

☐ ECM Provider bills ECM outreach via claims and is reimbursed**.**

☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member No Longer Eligible for Services – Incarcerated (Discontinuation Reason: 5)**

Member Declines Participation in ECM

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.

☐ Member declines participation in ECM.

☐ ECM LCM will document the outreach by entering a contact form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Refused to Speak or Requested No Further Contact. ECM Provider bills ECM outreach via claims and is reimbursed.

☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member No Longer Needs Services or Declines Services (Discontinuation Reason: 6)**

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MIF/Referral Process Checklist

Member is in a duplicative program.

☐ ECM Provider conducts HIPAA Identity/Authorization Verification**.**

☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.

☐ If the ECM LCM identifies the member to be in a duplicative program, the ECM LCM will inform the member they do not qualify for the ECM Program.

☐ ECM LCM will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* ECM Provider bills ECM outreach via claims and is reimbursed.

☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member No Longer Eligible for Services: Duplicative program (Discontinuation Reason: 7)**

Member lost Medi-Cal Coverage

☐ ECM Provider checks Availity prior to outreaching the member and identifies member is no longer a Molina Medi-Cal Beneficiary.

☐ The ECM Provider discontinues further outreaches**,** and the ECM LCM will document the outreach by entering a contact form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Member lost Medi-Cal Coverage. **ECM Provider bills ECM outreach via claims and is reimbursed.**

☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member No Longer Eligible for Services: Lost Medi-Cal coverage (Discontinuation Reason: 8)**

Member switched health plans

☐ ECM Provider checks Availity and identifies the member is no longer enrolled with Molina. ECM Provider then identifies that the member switched to a different health plan.

☐ The ECM Provider discontinues further outreaches and the ECM LCM will document the outreach by entering a contact form in CCA. Purpose of Contact =ECM|Welcome Contact. The Outcome of Contact = Member switched health plans

☐ ECM Provider bills ECM outreach via claims and is reimbursed.

☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member No Longer Eligible for Services: Switched health plans (Discontinuation Reason: 9)**

Member moved out of the county

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.

☐ ECM Provider identifies that the member moved out of the county to a county that Molina does not contract in. ECM Provider will inform member they are unable to enroll in ECM and should refer to their new health plan's ECM program. NOTE: Even if the member moved to a county that your organization contracts in, the ECM Provider should assist the member with switching their Medi-Cal case to the new county.

☐ The ECM Provider discontinues further outreaches and the ECM LCM will document the outreach by entering a contact form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Member moved out of the county

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MIF/Referral Process Checklist
☐ ECM Provider bills ECM outreach via claims and is reimburse
☐ **ECM Provider complete a Closed Loop Referral Form with a status of Referral Loop Closed: Member No Longer Eligible for Services: Moved out of the county (Discontinuation Reason: 10)**

Member moved out of the country

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.

☐ Member informs the ECM Provider that they moved out of the country. ECM Provider informs member they are unable to enroll in ECM.

☐ The ECM Provider discontinues further outreaches and the ECM LCM will document the outreach by entering a contact form in CCA. *Purpose of Contact =ECM|Welcome Contact*. The Outcome of Contact = Member moved out of the country

☐ ECM Provider bills ECM outreach via claims and is reimbursed.

☐ **ECM Provider complete a Closed Loop Referral Form with a status of Referral Loop Closed: Member No Longer Eligible for Services: Moved out of country (Discontinuation Reason: 11)**

Member is deceased

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider is informed that the member passed away.

☐ The ECM Provider discontinues further outreaches and the ECM Provider will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Successful Contact. ECM Provider bills ECM outreach via claims and is reimbursed.

☐ **ECM Provider complete a Closed Loop Referral Form with a status of Referral Loop Closed: Member No Longer Eligible for Services: Member is deceased (Discontinuation Reason: 14)**

Unsafe Behavior or Environment

☐ Member exhibits unsafe behavior or environment is unsafe.

☐ ECM Provider has discussion with their supervisor regarding member. ECM Provider staff and supervisor agree that member should not be enrolled in the program.

☐ The ECM Provider discontinues further outreaches and the ECM Provider will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Unsafe Behavior or Environment. ECM Provider bills ECM outreach via claims and is reimbursed.

☐ **ECM Provider complete a Closed Loop Referral Form with a status of Referral Loop Closed: Service Provider Declined (Discontinuation Reason: 12)**

Member does not meet any Population of Focus.

☐ ECM Provider conducts HIPAA Identity/Authorization Verification.

☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.

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MIF/Referral Process Checklist

- [ ] ECM Provider identifies that the member does not meet at least one Population of Focus. ECM Provider informs member they are unable to enroll in ECM.
- [ ] If the member does not meet any of the pre-identified Populations of Focus, nor any other Population of Focus, the ECM Provider will inform the member they do not qualify for the ECM Program.
- [ ] ECM Provider will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Successful Contact. If the ECM LCM identifies that the member has care coordination needs, the ECM Provider will answer "Yes" to question "Does the member have outstanding care coordination needs (and you'd like to refer them to Molina's Case Management?" A Molina CM representative will connect with the member. The ECM Provider may also refer to CHW.
- [ ] **ECM Provider complete a Closed Loop Referral Form with a status of Referral Loop Closed: Member No Longer Eligible for Services: Member does not qualify for at least one Population of Focus (Discontinuation Reason: 15)**

Note: If a member is UTC or declines participation into ECM and they are not enrolled, DO NOT complete a Disenrollment form.

Bottom-up Referral Process Checklist
(Non-presumptive authorization)

- [ ] ECM Provider meets member in the community and conducts HIPAA Identity/Authorization Verification.
- [ ] ECM Provider checks Availity to confirm member is eligible with Molina, is a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM status. ECM status indicates member is not enrolled in ECM.
- [ ] ECM Provider completes a referral form and submits it to Molina's ECM Team.
- [ ] Molina's ECM Team reviews, processes referral, and notifies the referring provider that the member has been assigned to them. NOTE: If Molina's ECM Team determines the member is not enrolled with Molina, or does not have Medi-Cal, or is enrolled in ECM and receiving services with another provider, the referral will be denied.
- [ ] ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member & completes steps in "Enrollment Process Checklist: Pre-enrollment (Successful Outreach)."
- [ ] Follow the CLR process.

Presumptive Authorization Process Checklist

- [ ] ECM Provider meets member in the community and conducts HIPAA Identity/Authorization Verification.

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- ☐ ECM Provider checks Availity to confirm member is eligible with our Plan, is a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM status. ECM status indicates member is not enrolled in ECM.
- ☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member & completes steps in "Enrollment Process Checklist: Pre-enrollment (successful Outreach)."
- ☐ ECM Provider completes a referral form, indicates it's a presumptive authorization, provides the ECM Benefit Start Date, and submits it to Molina's ECM Team.
- ☐ Molina's ECM Team reviews, processes referral, and notifies the referring provider that the member has been assigned to them.
- ☐ NOTE: If Molina's ECM Team determines the member is not enrolled with Molina, or does not have Medi-Cal, or is enrolled in ECM and receiving services with another provider, the referral will be denied, and the provider will not be reimbursed.
- ☐ Follow CLR process.

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

Pre-enrollment (MIF Members)

- ☐ ECM Provider conducts HIPAA Identity/Authorization Verification.
- ☐ ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.
- ☐ Member meets the ECM Program Eligibility and at least one Population of Focus
- ☐ ECM Provider successfully outreaches their MIF member, confirms member qualifies for ECM, agrees to enroll in ECM, and provides verbal agreement for data sharing.
- ☐ ECM Provider enrolls the member by completing the ECM Enrollment Assessment in CCA.
- ☐ ECM Provider assigns an ECM Lead Care Manager (LCM) to the member within **five business days** of enrolling a member
- ☐ ECM Provider and member agree on a follow-up date to complete the **Comprehensive Assessment** and develop the care plan *(Best Practice: Initiate the **Comprehensive Assessment** within 30 business days from enrolling a member but complete no later than 60 days from enrollment date, and complete the care plan within two business days of **Comprehensive Assessment.*** ECM Provider documents enrollment outreach via the Contact Form in CCA.
  - *Purpose of Contact =ECM|Welcome Contact*
- ☐ ECM Provider complete a Closed Loop Referral Form with a status of **Referral Loop Closed: Member Enrolled into ECM Program**

Pre-enrollment (Referred Members)

- ☐ Molina ECM Team will assign members and send confirmation via secure email to the ECM Provider and will request that the **ECM Provider** enroll the referred member via the ECM Enrollment Assessment in CCA within 5 business days.

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Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

- [ ] ECM Provider conducts HIPAA Identity/Authorization Verification.
- [ ] ECM Provider reviews the ECM Program Eligibility and Populations of Focus with the member.
- [ ] Member meets the ECM Program Eligibility and at least one Population of Focus
- [ ] ECM Provider assigns an ECM Lead Care Manager (LCM) to the member within **five business days** of enrolling a member
- [ ] ECM LCM to add themselves to the Address Book in CCA
- [ ] ECM Provider documents enrollment via the Contact Form in CCA.
  - *Purpose of Contact =ECM|Welcome Contact*
- [ ] ECM LCM outreaches members within **_five business days_** of enrolling the member (1st outreach)

Post-enrollment (All Enrolled Members)

- [ ] Molina will automatically mail the ECM Notification Letter to the member's PCP after a member has been enrolled in the ECM program.
- [ ] ECM LCM checks Availity before contacting member to ensure the member is still eligible with our Plan, continues to be a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM status.
- [ ] ECM LCM also conducts a pre-call review and reviews all available member information (e.g., clinical notes, HEDIS/Gaps in Care Report, Member Activity Report, etc.).
- [ ] ECM LCM contacts member within 5 business days of the member enrolling in the ECM Program.
- [ ] ECM Provider conducts HIPAA Identity/Authorization Verification.
- [ ] ECM LCM provides the member with their contact information, asks member for preferred contact method and agree on dates/times for continued engagement.
- [ ] ECM LCM also confirms member's authorized support person(s).
- [ ] If member agrees, ECM LCM will start on the Comprehensive Assessment or agree on a follow-up date/time to start the Comprehensive Assessment.
- [ ] ECM Provider will review the Member Activity Report (outbound by Molina via the sftp site). Enrolled members should also appear in this report
- [ ] ECM LCM mails the Welcome Letter to the member within **three business days** of enrolling the member and documents that the letter was mailed to the member via the Contact Form in CCA.
  - *Purpose of Contact =ECM|Welcome Contact*
- [ ] Within **five business days** of assigning an ECM LCM to the member, the ECM LCM documents 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 the Contact Form in CCA.

Post-enrollment (Comprehensive Assessment & Care Plan)

- [ ] ECM LCM checks Availity prior to engaging the member to ensure member is still eligible with our Plan, continues to be a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM status.

MOLINA HEALTHCARE

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

- ☐ ECM LCM conducts pre-call review by viewing data available in CCA like the Member Dashboard prior, checks the monthly HEDIS/Gaps in Care Report (or CCA Alerts) and if the member has a recent HIF assessment prior to engaging the member

- ☐ ECM LCM primarily engages with the member in-person & conducts HIPAA Identity/Authorization Verification.

- ☐ ECM LCM documents that Availity was checked and that the pre-call review was completed via the Contact Form in CCA. Purpose of Contact: ECM|Pre-Call Review|Gaps in Care Review

- ☐ ECM LCM starts the Comprehensive Assessment with the member within 30 days of the member enrolling into the ECM Program and completes it within 60 days of the member enrolling into the ECM Program via Contact Form in CCA.

- ☐ ECM LCM and member narrow down the main health concerns to at least 1 to 2 problems based on the completed Comprehensive Assessment.

- ☐ ECM LCM to mail PHQ-9 PCP Notification Letter to <u>enrolled member's PCP</u>) if the member indicated "several days" or more responses on the PHQ-9 questions section when completing the Comprehensive Assessment. **<u>This letter is unavailable in CCA; Molina ECM Team has provided the template</u>**

- ☐ ECM LCM creates an individualized & person-centered care plan with the member no later than 90 days from the member enrolling into the ECM Program. ECM LCM reviews developed care plan with member and obtain member consent on agreed upon care plan.

- ☐ Main health concern is incorporated into ECM care plan as Main Case Name (i.e. *ECM- Diabetes*) and all other active concerns as identified in the **Comprehensive Assessment** including Behavioral health and community-based Support services, i.e. LTSS. ECM LCM will also update the care plan based on outcome(s) of condition-specific assessments.

    i. Goals should be written in SMART format with all outcomes measurable and prioritized

    ii. ECM care plan contains Problem, Goal, Intervention, Outcome, and Barrier

    iii. ECM LCM conducts ICT with Clinical Consultant and discusses the member's **Comprehensive Assessment** and care plan. The Clinical Consultant provides input (as needed). Clinical Consultant will document their review via the Contact Form in CCA. ECM LCM will discuss the updated care plan with the member and obtain the member's consent when developing the care plan and every time the care plan is updated. This should be documented in a Contact Form.

- ☐ ECM LCM will mail a copy of the Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the care plan to the member's PCP along with the PCP ECM Care Plan letter no later than 14 business days of updating the care plan.

- ☐ ECM LCM documents the completion of the **Comprehensive Assessment**, discussion of care plan goals with the member, and notes member consent was obtained via the Contact Form in CCA.

    o *Purpose of Contact =ECM|Assessment|Care Plan Development / Revision* (if both the Comprehensive Assessment and Care Plan were completed on the same day)

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

☐ If a member requested the Advance Directives booklet during the completion of the Comprehensive Assessment **and** never received the information or if the member needs to read the booklet in a different language **-** Task Janna Hamilton for "5 wishes" in CCA

Post-enrollment (Post Completion of Initial Comprehensive Assessment & Care Plan)

☐ ECM LCM engages member every month and provides ECM services; this includes educating/coaching the member and their family/support group, addressing the care plan goals, and assists with care coordination needs.

☐ ECM LCM will refer members to services such as community support services, LTSS, IHSS, etc., as applicable and close loop on these referrals.

☐ ECM LCM checks Availity before member encounter to ensure the member is still eligible with our Plan, continues to be a Medi-Cal Beneficiary, does not have any hold restrictions, and their current ECM status.

☐ ECM LCM will continue to complete the pre-call review by viewing data available in CCA like the Member Dashboard prior, checks the monthly HEDIS/Gaps in Care Report (or CCA Alerts) and if the member has a recent HIF assessment prior to engaging the member. This will help detect new patterns of care.

☐ ECM LCM will continue to document that Availity was checked and that the pre-call review was completed via the Contact Form in CCA.

   o *Purpose of Contact: ECM|Pre-Call Review|Gaps in Care Review*

☐ ECM Provider will continue to report all outreaches (regardless of outcome) via the Contact Form in CCA and clearly note the outcome of the contact

☐ ECM Provider will continue to update the care plan with the member. The care plan must be updated every three (3) months at a minimum from the last update or more frequently upon changes in the member's health status or condition.

☐ **ECM LCM updates the care plan with the member at a frequency that is appropriate to the member's individual progress of changes in needs.**

☐ **ECM LCM continuously engages with the Clinical Consultant for clinical input.**

☐ ECM Provider will review the Weekly Member Activity Report (outbound by Molina via the sftp site) as part of their oversight and monitoring activities. Molina recommends that our ECM Providers conduct internal audits to ensure compliance with Molina/Regulatory requirements.

☐ Any member with low acuity or well-managed members should be reassessed for program graduation or referred to Molina CM or CHW for a lower level of care.

Case Conferences (ICT Meetings)

☐ ECM LCM coordinates with the member's ICT and actively participates in discussions to help ensure that the member's care is continuous and integrated among all service providers.

☐ ECM LCM updates the care plan based on the ICT meeting recommendations.

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Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

☐ The updated care plan is shared with the member, their assigned PCP, and other members of the care team as appropriate, as outlined in the Comprehensive Assessment and Care Plan section of this manual.

☐ ECM LCM will report all ICT meetings via the Contact Form in CCA.

    o *Purpose of Contact: ECM|ICT Meeting*

BH Crisis Line, NAL, HEDIS Behavioral Health Encounters, & High-Risk Members

☐ Molina's ECM Team notifies the ECM Provider if any of their assigned enrolled members have called the BH Crisis Line or had an Emergency Department Visit for Mental Illness and/or Alcohol and other drug abuse or dependence recently, or called the Nurse Advise Line (NAL) and needs follow-up, as well as members who are identified to be high risk and need a post-suicide contact.

☐ ECM LCM follows up with the member and assists the member with any care coordination needs.

☐ ECM Provider will document outreach via the Contact Form in CCA:

    o *Purpose of Contact =ECM|Follow-up* (for NAL follow-up)

    o *Purpose of Contact= ECM| BH Crisis Call Follow-Up* (for BH Crisis Follow-up)

Transitions of Care

☐ ECM LCM reviews the outbounded Daily IP Census Report, Molina ECM Team notifications, and any other tools that help identify members who have been hospitalized or in an SNF. ECM LCM must use all tools at their disposal to identify and interact with recently admitted/discharged members.

☐ ECM LCM follows up with the member via telephone within two business days of discharge (or agreed upon date if contact is made with the member before discharge) to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist.

☐ ECM LCM conducts an in-person or phone call outreach within seven business days from discharge. Best practice to conduct a face-to-face visit, to determine the member's post-inpatient status and any further care needs and discusses the Transition of Care Questions.

☐ ECM LCM collaborates, communicates, and coordinates with all involved parties.

☐ ECM LCM updates the care plan post-discharge to address hospitalization and measures to prevent readmission.

☐ ECM LCM discusses the updated care plan with their clinical consultant for clinical input.

☐ ECM LCM discusses the updated care plan with the member and obtain the member's consent.

☐ ECM LCM mails a copy of the updated care plan and ECM Care Plan letter to the member, as well as provides a copy of the updated care plan to the member's PCP along with the PCP ECM Care Plan letter, & any parties involved in the member's care within 14 business days of updating the care plan.

☐ ECM LCM coordinates of all services for members during and post-care transitions from lower acuity facilities/departments (emergency departments, skilled nursing facilities, residential/treatment centers, incarceration facilities, etc. For Homeless members, the ECM LCM plans an appropriate place for the member to stay post-discharge from the hospital or SNF, including temporary or permanent housing, and explores Community Support referrals.

☐ ECM Provider will document all TOC-related outreaches via the Contact Form in CCA.

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

○ *Purpose of Contact: ECM|Post Discharge Outreach| Assessment|Care Plan Development/ Revision|Coordination of Services*

Program Completion Questionnaire (PCQ)

☐ ECM LCM completes the PCQ at a frequency that is appropriate for the member's individual progress or changes in needs.

☐ Based on PCQ responses, ECM LCM will determine if member is ready to graduate from the ECM Program or needs to be downgraded to a lower level of care or needs to continue with the ECM Program.

☐ ECM Provider will document all **PCQ** and Care Plan outreaches via the Contact Form in CCA*.*
  ○ *Purpose of Contact: ECM\|Assessment/PCQ*

Medi-Cal SPD Members

☐ Molina's ECM Team notifies the ECM Provider if any of their enrolled members change to Medi-Cal SPD.

☐ **ECM LCM ensures the member has a completed Comprehensive Assessment on file no later than 30 days of the member's enrollment into Medi-Cal SPD.**

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Grievance Process Checklist

A complaint (or grievance) is when a member has a problem with Molina Healthcare or a provider or the health care or treatment they received from a provider. The member has the right to file a grievance with Molina Healthcare to tell us about their problem. When identifying such problems, the ECM LCM should encourage the member to file a grievance and assist the member in filing the grievance.

Grievance Process Checklist
☐ ECM member discusses complaint/grievance with their ECM LCM.
☐ ECM LCM encourages members to file a grievance and assists the member with filing the grievance by contacting Member Services.
☐ Member Services routes the grievance to the Appeals & Grievance Team.
☐ Appeals & Grievance Team reviews and routes the grievance to Molina's ECM Team to request information.
☐ Molina's ECM Team provides member's assigned ECM LCM contact information to the Appeals & Grievance Team
☐ Molina's ECM Team routes the Grievance Response Form to the assigned ECM Provider and gives them 48-72 hours to respond to the questions in the form.
☐ Depending on the grievance, the ECM LCM might need to make another outreach to the member.
☐ ECM Provider submits their completed Grievance Response Form to Molina's ECM Team.
☐ Molina's ECM Team reviews the Grievance Response Form and routes it to the Appeals & Grievance Team.
☐ Appeals & Grievance Team reviews and might ask for updates and/or additional information.
☐ Appeals & Grievance Team might also contact the assigned ECM LCM for information.
☐ Molina's ECM Team contacts the ECM Provider and requests an update and/or additional information.
☐ The requested information gets routed to the Appeals & Grievance Team.
☐ Appeals & Grievance Team mails a resolution letter to the member and include the assigned ECM LCM's contact information.
☐ ECM Provider is to document grievance and notes in CCA as a Progress Note.

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Disenrollment Process Checklist

ECM LCMs should only disenroll members enrolled in ECM and ready to be disenrolled from the program. A disenrollment is not needed for MIF members who declined ECM or are UTC.

<table>
<tr><td colspan="2" align="center">**Disenrollment Process**</td></tr>
<tr><td colspan="2" align="center">**UTC Members**</td></tr>
<tr><td>☐</td><td>The ECM LCM will complete two months' worth of attempts; this includes four non-mail attempts and mailing the *ECM Post Opt-In UTC Letter* to the address on record (in CCA) during month one and then if the member continues to be UTC, extend those attempts to the 2nd month (3 additional non-mail attempts and mailing the *ECM Post Opt-In UTC Letter).* If the member continues to be UTC by the end of the 2nd month, the ECM LCM will proceed with disenrolling the member from the program by completing the Disenrollment Form in CCA and indicating the disenrollment reason: *ECM LCM has been unable to connect with the member after multiple attempts.* The member will need to be disenrolled no later than the last day of the 2nd month.</td></tr>
<tr><td>☐</td><td>After mailing the *ECM Post Opt-In UTC Letter to the member,* the ECM LCM should *wait a couple of days (recommend waiting about one week)* to allow time for the member to receive the letter and reach out to their ECM LCM. Do not mail the letter on the same day you are disenrolling the member. If the member continues to be UTC within a week of mailing the letter, the ECM LCM should proceed with disenrolling the member from ECM no later than the last day of the month.</td></tr>
<tr><td>☐</td><td>ECM LCM will document all outreaches via the Contact Form in CCA. The Outcome of Contact = Left Message, Disconnected, Invalid Phone #, No Answer, Requested Later Contact. The Outcome of Contact for mailing letter=Other. The Outcome of Contact Other: Mailed Letter</td></tr>
<tr><td>☐</td><td>ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*
    ▪ *Exhausted non-mail attempts, mailed ECM Post Opt-In UTC Letter*</td></tr>
<tr><td colspan="2">**ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments**.</td></tr>
<tr><td colspan="2" align="center">**Member who declined ECM**</td></tr>
<tr><td>☐</td><td>For members who no longer wish to be in the ECM Program, the ECM LCM will proceed with disenrolling the member from the program by completing the *Disenrollment Form* and indicating disenrollment reason: *Member no longer wishes to receive ECM or is unwilling to engage.* ECM LCM should not delay disenrolling the member from ECM if the member declines ECM. ECM LCM is to use the decline date as the date of disenrollment in the Disenrollment Form in CCA.</td></tr>
<tr><td>☐</td><td>ECM LCM will mail the Post Opt-In Decline letter to the member before disenrolling the member from ECM. If the ECM LCM is unable to mail the Post Opt-In Decline Letter to a member due to no address on record or the wrong address, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form.</td></tr>
<tr><td>☐</td><td>ECM LCM will document the outcome of the member discussion (member declined ECM) via the Contact Form in CCA, in addition to documenting (separately) that the Post Opt-In Decline Letter was mailed to the member. The Outcome of Contact = Requested No Further Contact. The Outcome of Contact for mailing letter=Other. The Outcome of Contact Other: Mailed Letter</td></tr>
</table>

Disenrollment Process

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*
  - ▪ *Member declined ECM, mailed ECM Post Opt-In Decline Letter*

ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Member who met all care goals

☐ For members who are ready to graduate from the ECM Program because they are well-managing their conditions and have met all their care plan goals, the ECM LCM will proceed with disenrolling the member from the program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *All care goals are met.*

☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are graduating from the ECM Program) via the *Contact Form Template.*

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*
  - ▪ *Member is ready to graduate. Discussed with the member, and the member agreed.*

ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Member is ready to transition to a lower level of care

☐ If the ECM LCM identifies that the member is ready to be downgraded to a lower level of care management (Molina CM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the *Disenrollment Form* and indicating disenrollment reason: *Member is ready to transition to a lower level of care*

☐ ECM LCM will document the outcome of the member discussion (ECM LCM informing the member they are being referred to Molina's CM and are being disenrolled from the ECM Program) via the *Contact Form in CCA.*

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*
  - ▪ *Completed direct referral to Molina's CM*

☐ ECM LCM will complete the Direct Referral to Molina CM in CCA before disenrolling the member

ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Member is enrolled in a duplicative program.

☐ If the ECM LCM identifies that the member is in a duplicative program (e.g., hospice, CCM, MSSP, Accordant, etc**.**), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Member is enrolled in a duplicative program.*

☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are already receiving the same care management services through another program) via the Contact Form in CCA*.*

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*

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Disenrollment Process

- *Member in CCM and requested to opt-out of ECM*

ECM LCM will close the member's milestones, ECM care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Member not enrolled in Molina Medi-Cal Program.

☐ If the ECM LCM identifies that the member has lost eligibility with Molina Medi-Cal Program (reviewed Availity or member informed ECM LCM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Not enrolled with Molina Medi-Cal program.*

☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the Molina Medi-Cal Program) via the Contact Form in CCA.

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*

- *Member lost eligibility with Molina*

ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Member passed away.

☐ If the ECM LCM identifies that the member has passed away, the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the *Disenrollment Form in CCA* and indicating the disenrollment reason: *Member passed away.*

☐ ECM LCM will document the outcome of the discussion with the individual who informed ECM LCM that the member passed away (e.g., member's family or friend) via the Contact Form in CCA.

☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*

- *Informed by the member's sister, Jane Smith, that member passed away on 9/1/2022*

ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.

Note

Once a member is disenrolled from the ECM Program, the member becomes restricted in CCA, and you can no longer access the member's profile.

An ECM Enrollment Assessment does not need to be completed after disenrolling a member.

Member is Incarcerated.

☐ If the ECM LCM identifies that the member has been incarcerated, the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Incarcerated.*

☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are incarcerated) via the Contact Form in CCA.

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Disenrollment Process
☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*   ▪ *Member lost eligibility with Molina* **ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.**
Member switched Health Plans
☐ If the ECM LCM identifies that the member has lost eligibility with Molina Medi-Cal Program (reviewed Availity or member informed ECM LCM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Switched Health Plans* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the Molina Medi-Cal Program) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*   ▪ *Member lost eligibility with Molina* **ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments**.
Member moved out of the county.
☐ If the ECM LCM identifies that the member has moved out of the county (member informed ECM LCM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Moved out of the county.* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the county in which they were being provided services) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*   ▪ *Member lost eligibility with Molina.* **ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments**.
Member moved out of the Country.
☐ If the ECM LCM identifies that the member has moved out of the Country (member informed ECM LCM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Moved out of the country.* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the county in which they were being provided services) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*

Disenrollment Process
▪ *Member lost eligibility with Molina*
ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Unsafe behavior or environment
☐ If the ECM LCM identifies that the behavior or environment is unsafe to work in, the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Unsafe behavior or environment***.** ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the county in which they were being provided services) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:*   ▪ *Member lost eligibility with Molina***.** **ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments**.
Returning Members
If the member returns your call after they have been disenrolled from ECM and wishes to continue with the ECM Program, the member will need to be re-enrolled. Please complete a Molina ECM Referral Form and submit it to Molina's ECM Team: MHC_ECMReferrals@MolinaHealthcare.com. Molina's ECM Team will contact you with the next steps.

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Molina ECM Reports

Below is a list of all the reports that Molina's ECM Team provides to or requests from our ECM Providers. ECM Providers are expected to review these reports. If you encounter any discrepancies with any of these reports, please notify Molina's ECM Team immediately: MHC_ECM@MolinaHealthcare.com

Report	Description	Format	Method of Distribution	Frequency
Staffing & Capacity	ECM Providers are to report their staffing and capacity for their ECM Team. Reach out to Molina's ECM Team for latest reporting template.	Excel File	Manually via email	Due Monthly to Molina on the 25th
Member Information File (MIF)	List of all ECM eligible members assigned to each ECM Provider. (This list excludes any approved referrals). Includes continued eligible, newly eligible, termed, and returned. For use in outreach and enrollment. Refer to the report for all fields.	Excel file	sFTP	Monthly
Member Activity Report (MAR)	List of all enrolled ECM members. ECM Providers must review this report as part of their oversight and monitoring activities and reconcile against capitation reports. Refer to the report for all fields.	Excel file	sFTP	Weekly on Mondays
IP Census Report	ECM Eligible & Opt-in members who are currently inpatient (Hospital & SNF). Utilize this report for transition of care (ToC) activities (enrolled members) and outreach & engagement (members not enrolled). Refer to the report for all fields.	Excel file	sFTP	Daily
HEDIS/Gaps in Care Report	Preventative care measures. ECM LCM is to educate the	Excel file	sFTP	1st of the Month

	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. Refer to the report for all fields			
Monthly Capitation Details	Report includes post-enrollment payments, member details, and recoupments. Refer to the report for all fields. Refer to steps below to download this report. .	Excel	FES	Monthly
Scorecards	Scorecard identifies gaps for enrolled members who have not contacted such as, members without an initial Comprehensive Assessment completed, and members who do not need a re-assessment, members without an ECM Care Plan, and members without an assigned ECM LCM. ECM Providers must review this report as part of their oversight and monitoring activities and reconcile against capitation reports.	Excel	sFTP	1st of the Month

Note: Reports may have a time lag of one or two business days due to the overnight update process.

ECM Payment Information

ECM Providers can download the Capitation Details Report by accessing the File Exchange Services (FES) Portal. This report is available within one day of the capitation payment being generated.

For FES access requests, ECM Providers need to email Provider Service Representative:

- Email Subject: FES Access
- Provide the full name of the individual who needs access.
- Name of the organization.
- Individual's email address

ECM Providers are encouraged to request access for at least two employees: a Finance/ Accounting Department contact and an individual from your assigned Provider Service Representative.

- Upon being granted access, users will receive an email with the FES login and password.
- Access FES at the following link: fes.molinahealthcare.com/FES/login.
- For password resets or login information, email the Molina EDI Team at the following mailbox: edi.encounters@molinahealthcare.com.
- We recommend using the EDI email address to report issues rather than the phone number on the portal, as the email has a faster response time.
- Note that if you contract with Molina for multiple programs/lines of business other than ECM (e.g., Medi-Cal, Medicare, Marketplace), you will need two different logins: one for ECM and one for all other lines of business.

Instructions
Step 1: Upload File
After logging into the FES portal, click on the Upload File header. The upload file page will be displayed.
Below fields should be displayed.
- File Format   - Trading Partner   - Exchange Name   - File to be uploaded.
Select the file format, Trading Partner and Exchange Name. Then select the file to be uploaded and click on upload.

Step 2: Download File

Below page will be displayed upon clicking on the Download File option.

Below fields should be displayed.

- Trading Partner
- File Category
- File Format
- From Date
- To Date

Enter all mandatory fields and click on search. Files related to search criteria should be displayed.

File Name	Format	Version	Sending Trading Partner ID	Receiving Trading Partner ID	Is Archived?	Sender ID	Submission Time	View Details
ANG_THRA_20180802.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/2/2018 11:05:58 AM	
ANG_TCNA_20180802.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/2/2018 11:05:58 AM	
ANG_FCNA_20180802.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/2/2018 11:05:58 AM	
ANG_ICP_20180802.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/2/2018 11:05:58 AM	
AffiliationByPCP_Capitation_Detail_ANGELES IPA_201808062024.xlsx	CAPDETAIL	1	MHC330342719	ANG954535099	No	Autosysprosvc	8/6/2018 8:26:08 PM	
ANG_RSKSRAT_20180807.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/7/2018 11:15:30 AM	
ANG_COC_20180807.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/7/2018 11:15:30 AM	
ANG_FCNA_20180817.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/17/2018 11:25:27 AM	
ANG_ICP_20180817.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/17/2018 11:25:27 AM	
ANG_THRA_20180817.CSV	ClaimHistory	Proprietary	MHC330342719	ANG954535099	No	Autosysprosvc	8/17/2018 11:25:37 AM	

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Instructions

Click on the View Details icon in the last grid of each file to view file details.

Click on the file name link to open or save the files.

Step 3: File Submission History

Below page will be displayed upon clicking on the File Submission History option.

Below fields should be displayed.

- Trading Partner
- File Category
- File Format
- From Date
- To Date

Enter all mandatory fields and click on search. Files related to search criteria should be displayed.

Click on the file name link to file details.

Step 4: View Exchange

Below page will be displayed upon clicking on the View Exchange option.

Below fields should be displayed.

- Trading Partner
- File Category
- File Format

Instructions

Select the required fields and click on search. Search results will be displayed for the search fields entered.

Step 5: View Partner

Below page will be displayed upon clicking on the View Partner option.

Select Trading Partner from the list and click on search. Search results will be displayed for the search fields entered.

Instructions

Step 6: Encounter Report

Below page will be displayed upon clicking on the Encounter Report option.

Select an option from the list. Reports will be displayed for the selection.

Step 7: Contact Molina and Change the Password

Contact Molina page will be displayed when the user clicks on the link.
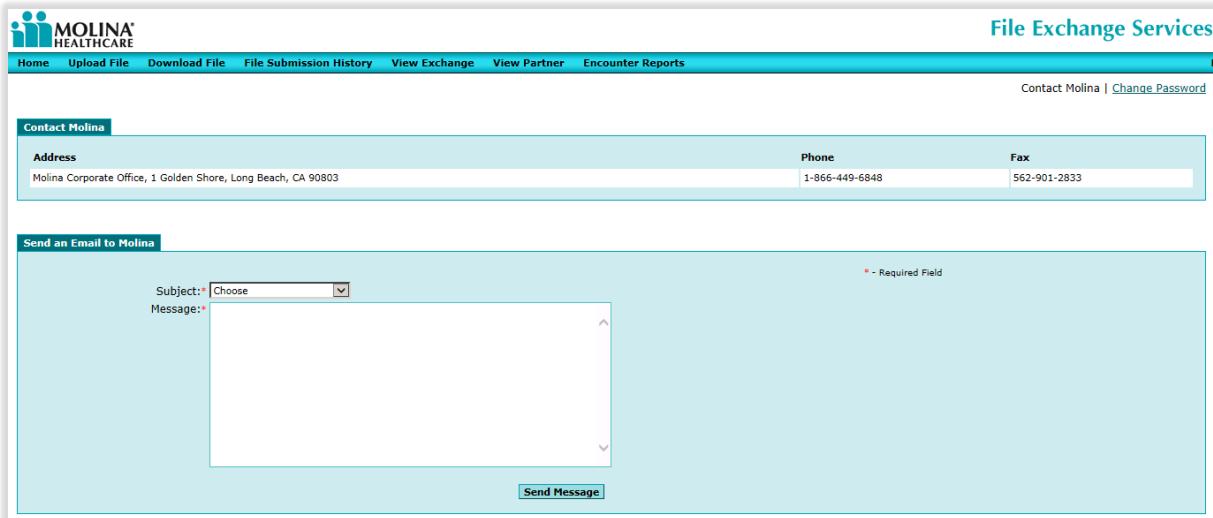
Change Password page will be displayed when the user clicks on the link.

ECHO Health Inc.

You may also choose to opt-in to receive electronic payment via a virtual credit card in our ECHO portal. Please visit ECHO Provider Payments - Login to set up an account.

EFT/ERA/835 Assistance – ECHO Health, a partner of Change Healthcare:

- ☐ Website: enrollments.echohealthinc.com/efteradirect/molinaHealthcare
- ☐ Provider Portal (ECHO): providerpayments.com/
- ☐ Phone: 888-834-3511
- ☐ Email: edi@echohealthinc.com or cs_requests@echohealthinc.com