MOLINA HEALTHCARE

Molina
Enhanced Care Management Provider Manual
CCA Users
Part 4

January 1, 2024

Table of Contents

MHC Healthcare Services- Enhanced Care Management

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 CA-HRA, 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 either the Clinical Consultant or the ECM LCM, who can document on behalf of 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, 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.

Clinical Consultant Reviews- Contact Forms

Clinical consultant reviews must be documented via a Contact Form in CCA. The ECM LCM can document on behalf of the Clinical Consultant. Documentation of Clinical Consultant name, credentials, and review and input of the HRA and ICP (if the ECM LCM holds an appropriate clinical license, no clinical consultant review is required). Each HRA, 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:

MHC Healthcare Services- Enhanced Care Management

Scenario #1: Post-enrollment. ECM LCM presented the member's care plan to their Clinical Consultant. The Clinical Consultant reviewed the care plan.
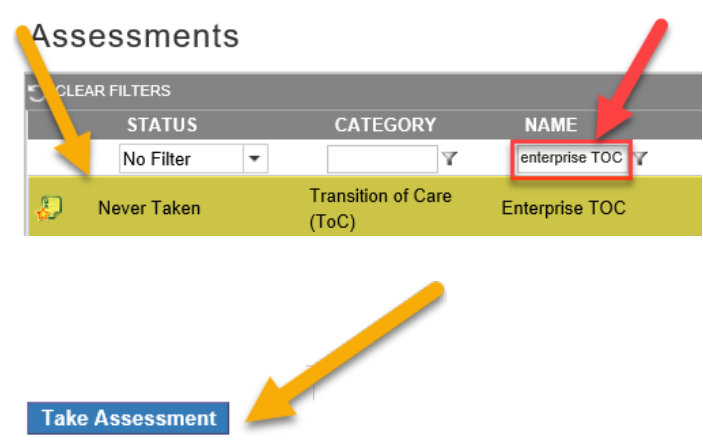
Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Clinical Consultant Review 4/10/23
Contact Type	Interdisciplinary Care Team
Contact Date	04/10/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	ECM Provider
Respondent 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 4/10/23, 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.

Transitions of Care

Molina will share hospital census data with ECM Providers electronically via sFTP. 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.
- A face-to-face visit should occur within **seven business days** from discharge to determine the member's post-inpatient status and any further care needs and complete the Transition of Care assessment.
- ECM LCMs are expected to collaborate, communicate, and coordinate with all involved parties.
- A new HRA should be administered to the member, and the care plan should be updated post-discharge to address hospitalization and measures to prevent readmission.
- Updated ECM ICP should be shared with the member, PCP, and any parties involved in the patient's care.
- 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."	

MHC Healthcare Services- Enhanced Care Management

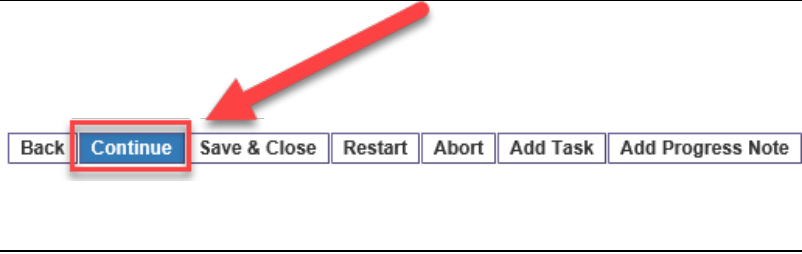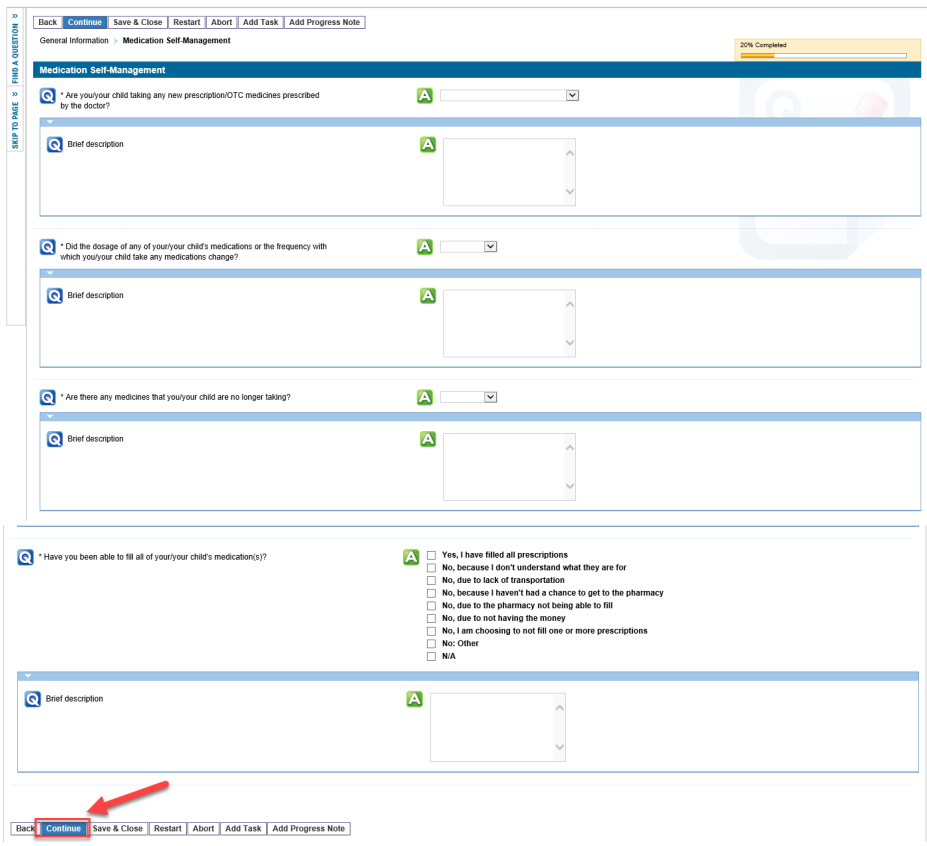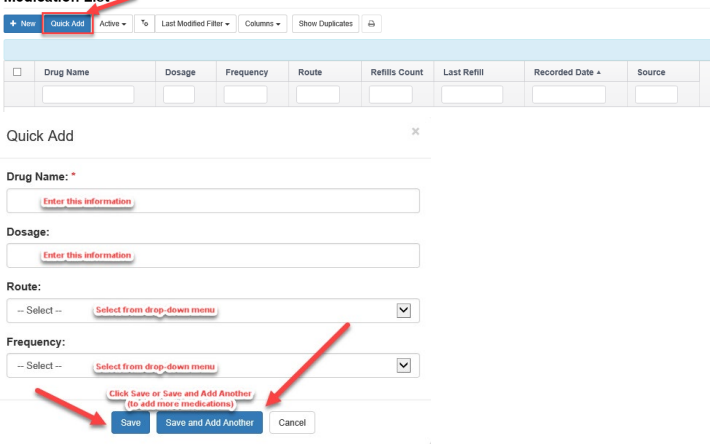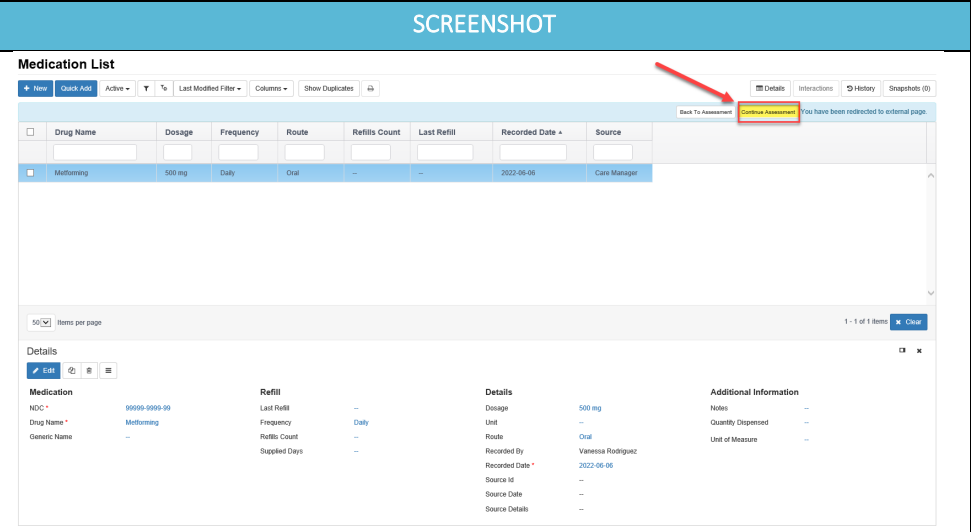| INSTRUCTIONS	SCREENSHOT

• 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.
	Enterprise TOC
	
	Back Continue Save & Close Restart Abort Add Task Add Progress Note
	General Information
	
	General Information
	* Admission Date
	* Discharge Date
	* Discharged from:
	* Discharged to:
	* Admission Diagnosis
	* Discharge Diagnosis
	* Respondent
	* Contact Method
	* What brought you/your child to the hospital?
	  □ Accident/Trauma/Injury (for ex: MVA, pedestrian, a fall, burns)
	  □ Elective procedure
	  □ New or worsening mental health symptoms
	  □ New or worsening physical symptoms
	  □ Other
	
	Brief description
	
	* Did you receive discharge instructions on the following?
	  □ Dietary information
	  □ How to care for yourself/your child
	  □ Medications to be taking
	  □ Scheduling follow-up appointments
	  □ Worsening symptoms
	  □ No, did not receive any instructions
	  □ I don't know
	
	Back Continue Save & Close Restart Abort Add Task Add Progress Note
	
	* Did you receive discharge instructions on the following?
	  □ Dietary information
	  □ How to care for yourself/your child
	  □ Medications to be taking
	  □ Scheduling follow-up appointments
	  □ Worsening symptoms
	  □ No, did not receive any instructions
	  ☑ I don't know
	
	Do you have any questions about your/your child's discharge instructions?
	  □ Yes, I have questions about diet
	  □ Yes, I have questions about caring for myself/my child
	  □ Yes, I have questions about medications
	  □ Yes, I have questions about scheduling follow-up appointments
	  □ Yes, I have questions about what symptoms to watch for
	  □ No, I have no questions
	  □ I don't know

MHC Healthcare Services- Enhanced Care Management

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

MHC Healthcare Services- Enhanced Care Management

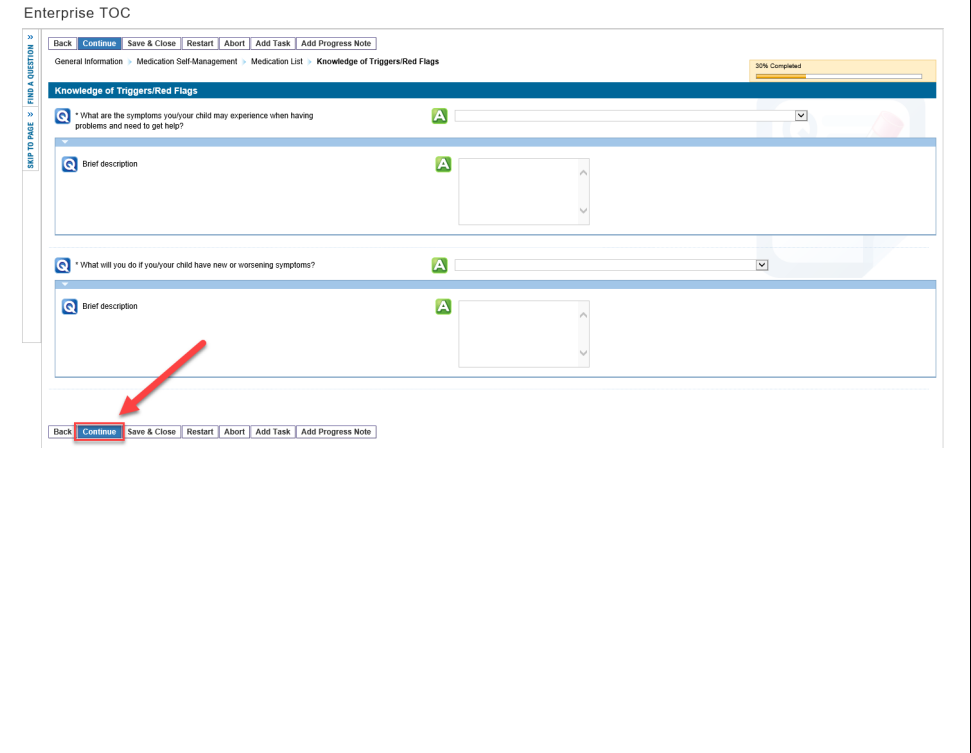| INSTRUCTIONS	SCREENSHOT
Assessment once all medications have been entered.	
Next, complete the Knowledge of Triggers/Red Flags section of the TOC Assessment: Here we are assessing member's understanding of the BH/ Physical Health related signs and symptoms of their condition and what to do when symptoms 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.	

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS	SCREENSHOT
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	Enterprise TOC **If Yes, already saw the doctor since being discharged, fill-out branching questions:**
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.	Enterprise TOC

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS	SCREENSHOT
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	Enterprise TOC
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.	Enterprise TOC

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS	SCREENSHOT
Next, complete the Personal Health Journal section of the TOC Assessment:	Enterprise TOC Personal Health Journal
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 Final Page
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 ECM - Diabetes CM9436038 Open

MHC Healthcare Services- Enhanced Care Management

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:

<u>Scenario #1:</u> 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 HRA, 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 - Best ECM Provider TOC Assessment Completion 6/1/23
Member First Name	John
Member Last Name	Smith
Contact Type	General Contact
Contact Date	06/01/2023
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	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 6/1/23, 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 HRA, 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.

MHC Healthcare Services- Enhanced Care Management

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. All forms are located on Molina's website: https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

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.

Community Supports	Imperial	Los Angeles (HN)	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	1/1/2022
Housing Deposits	7/1/2022	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	1/1/2022
Short-Term Post-Hospitalization	1/1/2024	1/1/2023	7/1/2022	7/1/2022	7/1/2022	1/1/2023
Recuperative Care (Medical Respite)	1/1/2024	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Respite Services	7/1/2022	1/1/2023	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Day Habilitation Programs	7/1/2022	1/1/2023	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	1/1/2023	1/1/2023	1/1/2024	1/1/2023	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	1/1/2023	1/1/2023	1/1/2022	1/1/2023	1/1/2022	1/1/2022
Personal Care and Homemaker Services	7/1/2022	1/1/2023	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Environmental Accessibility Adaptations (Home Modifications)	7/1/2023	7/1/2022	1/1/2023	7/1/2023	1/1/2023	7/1/2023

MHC Healthcare Services- Enhanced Care Management

Community Supports	Imperial	Los Angeles (HN)	Riverside	Sacramento	San Bernardino	San Diego
Medically Tailored Meals/Medically-Support Food	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Sobering Centers	1/1/2024	1/1/2022	1/1/2022	1/1/2022	1/1/2023	1/1/2022
Asthma Remediation	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022

The CS Referral Forms are located on Molina's website:
https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

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
Pregnancy Referral Form
Complex Case Management - External CM Referral Form
Case Management Referral Form
Behavioral Health Coordination of Care Form
Enhanced Care Management Member Referral Form
CS EAA Home Modifications Referral Form
CS Transition to ALF or RCFE Referral Form

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

Review the grids below for more information on Community Based Adult Services (CBAS) and In-Home Support Services (IHSS) and how to refer members:

Community-Based Adult Services (CBAS) and In-Home Support Services (IHSS) – Inland Empire (Riverside and San Bernardino County)

	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: • 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	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 • 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.

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
	• 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	
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 interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	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 Referral Process (cont.)	**Standard referral:** 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.	**Standard referral:** San Bernardino: Submit the county IHSS Referral form to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. Riverside: Contact the Department of Public Social Services (DPSS) to initiate an IHSS referral: Web Referral: https://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. **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. **Public Authority:** Submit an email to Molina

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
		through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com.
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.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

Community-Based Adult Services (CBAS) and In-Home Support Services (IHSS) – Los Angeles County

	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.

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
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: • 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	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 • 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	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.

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
	at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	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 Referral Process cont.	**Standard referral:** 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.	**Standard referral:** Submit Los Angeles County IHSS Referral Form to Molina through the Molina CA LTSS mailbox at: CALTSS@molinahealthcare.com. **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 **Public Authority-** Assist member in contacting Personal Assistance Service Council (PASC): (877) 565-4477
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	**Los Angeles County** • IHSS: (888) 944-4477 • IHSS Helpline: (888) 822-9622 • Public Authority: (877) 565-4477

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

	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: • 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)	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

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
	• 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 interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	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:** 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.	**Standard referral:** Contact Sacramento County In-Home Support Services directly: Phone: (916) 874-9471 **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 **Public Authority-** Assist member to contact

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
		Sacramento County IHSS Public Authority: (916) 874-2888
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	**Sacramento County** • IHSS: (916) 874-9471 • Public Authority: (916) 874-2888

Community-Based Adult Services (CBAS) and In-Home Support Services (IHSS) – San Diego County

	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. 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	IHSS services can include: • Housecleaning

MHC Healthcare Services- Enhanced Care Management

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
	• 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	• 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: • 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	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 • 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 interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	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.

	Community-Based Adult Services (CBAS)	In-Home Support Services (IHSS)
Referral Process	**Standard referral:** 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.	**Standard referral:** Contact Aging and Independence Services (AIS) to initiate an IHSS referral: Phone: (800) 339-4661 Web Referral: Register and complete referrals https://www.aiswebreferral.org/Account/Login.aspx?ReturnUrl=%2f **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member in contacting AIS: (800) 339-4661 **Public Authority-** Assist member in contacting San Diego IHSS Public Authority: (866) 351-7722
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	**San Diego County** • IHSS: (800) 339-4661 • Public Authority: (866) 351-7722

MHC Healthcare Services- Enhanced Care Management

Disenrolling Members from ECM

If a member needs to be disenrolled from ECM, the ECM LCM must complete the Disenrollment Form in CCA. <mark>Please note that a Disenrollment Form does not need to be completed for members not enrolled in the program.</mark>

 Below is the complete list of disenrollment reasons:

1. **All care goals are met**= 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.
2. **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.
3. **Member no longer wishes to receive ECM or is unwilling to engage**= 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.
4. **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.
5. **Incarcerated=** Member has been incarcerated.
6. **Member is 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.
7. **Not enrolled with Molina Medi-Cal program**= The member is no longer eligible for Medi-Cal benefits through Molina Healthcare.
8. **Switched Health Plans=** member switched health plans.
9. **Member moved out of the county=** member no longer resides in the county.
10. **Member moved out of the country=** member no longer resides in the country.
11. **Unsafe behavior or environment=** no longer a safe environment for the ECM LCM.
12. **Member passed away**= The member has expired.

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.
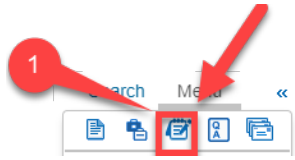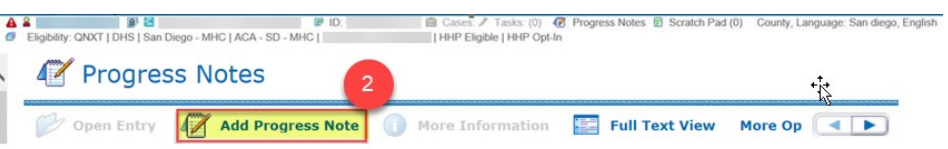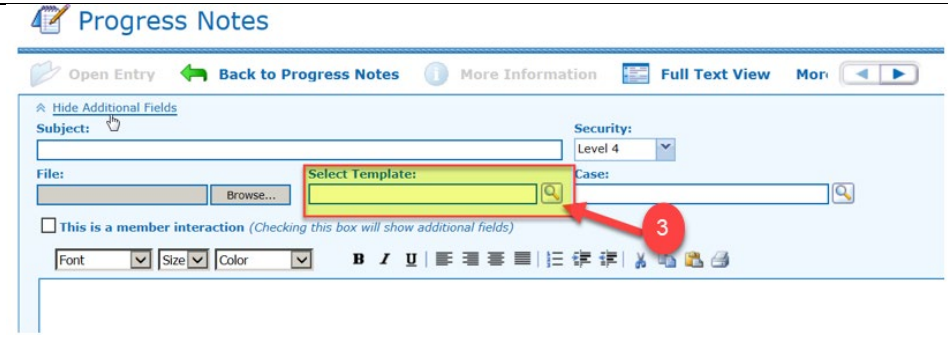
The ECM LCM must close the care plan, milestones, and pending tasks before completing the Disenrollment Form. In addition, the ECM LCM must remove themselves from the Assignments section in CCA and the Address Book before submitting the Disenrollment Form.

We defer to our ECM Providers to apply their own judgment to determine if a member should continue with ECM, must be 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 HRA reassessments they

MHC Healthcare Services- Enhanced Care Management
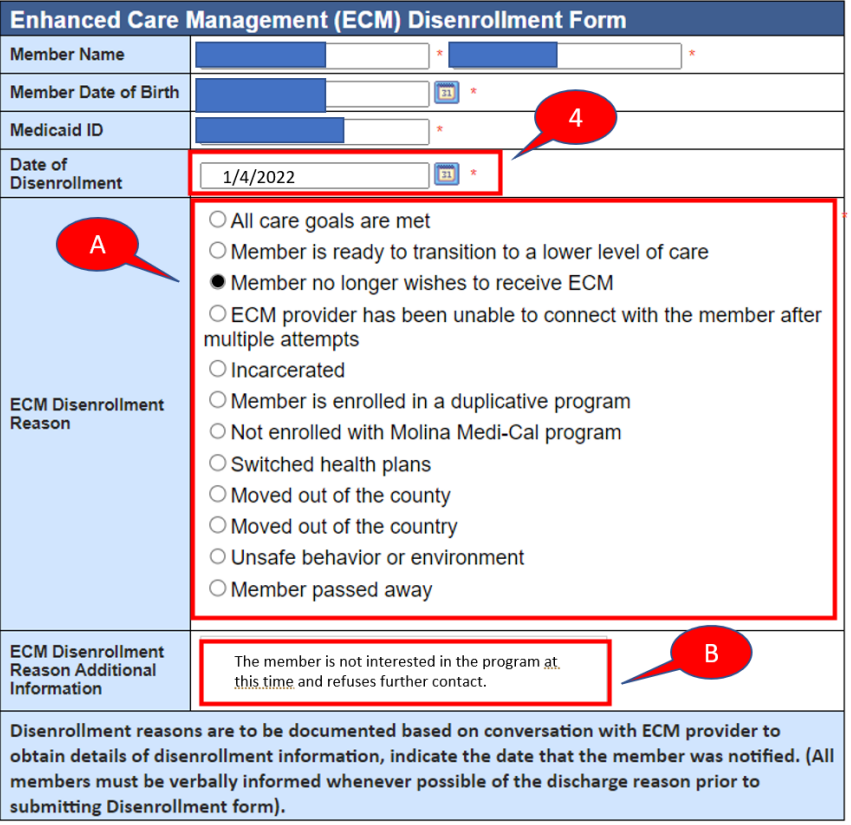
are required to complete with the member every six months (or sooner if there's a change in condition, i.e., hospitalization) if the same concerns exist, or if new ones have come up which still require the member to be managed through ECM. We want our ECM Providers also to consider the following when deciding this:

• Has the member's ED/ inpatient utilization gone down?

• Is the member self-managing, getting to appointments on their own? Taking their meds? Plugged in with PCP and specialists?
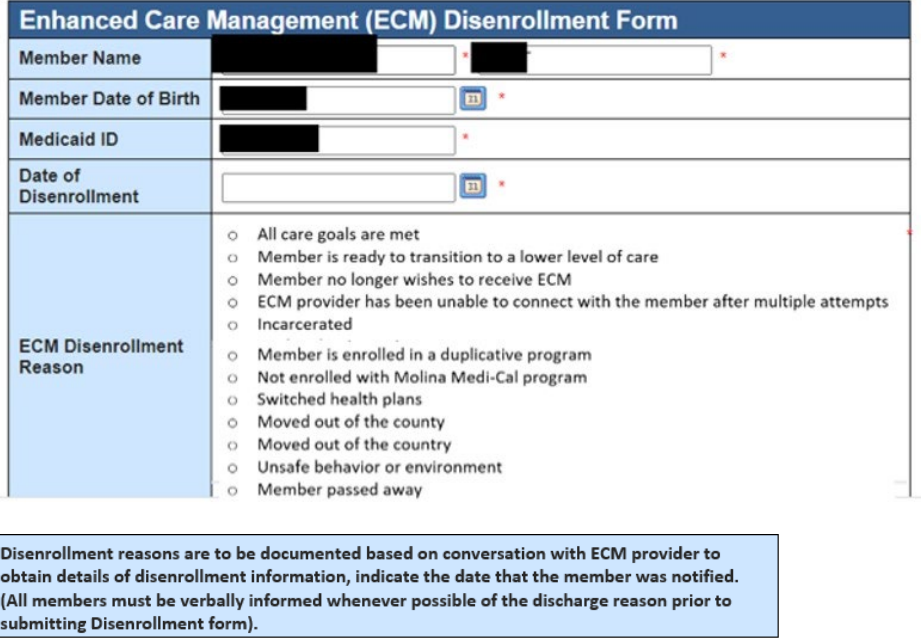
• Does the member have stable housing?

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.	
3. Use the magnifying glass to see the categories of progress notes. Next, from the list (A), expand the "Member	

MHC Healthcare Services- Enhanced Care Management

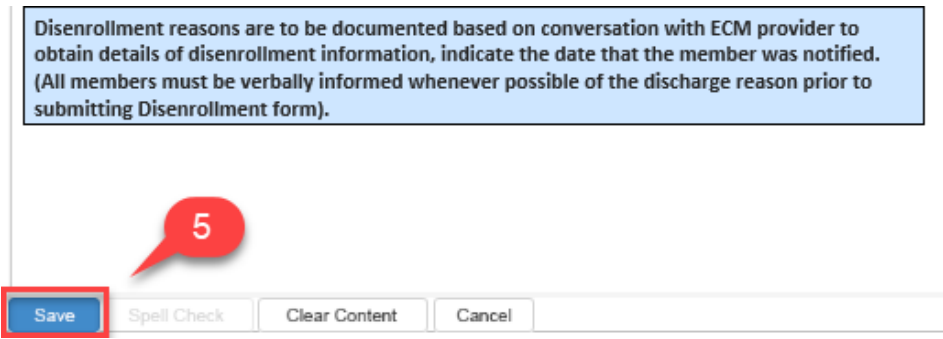| INSTRUCTIONS	SCREENSHOT
Contact Records – Molina" group,	**SELECT TEMPLATE** ⊞ **EXPAND ALL** ⊞ General Forms - Molina ⊞ Health Education Form - Molina ⊞ LTSS ⊞ Member Contact Records - Molina (A) ⊞ MMP Forms ⊞ Special Program Forms - Molina ⊞ Texas Forms ⊞ Waiver Service Forms

Then (B) highlight the ECM Disenrollment form and click "Select."	**SELECT TEMPLATE**
	
	⊞ **EXPAND ALL**
	
	⊞ General Forms - Molina
	⊞ LTSS
	⊟ Member Contact Records - Molina
	   10 & 30 Days Follow Up Contact Note
	   Auto Dialer Call Attempt
	   Contact Form
	   ECM Disenrollment Form
	   Member Texting Consent
	   MI MMP Member Contact Record
	   Nursing Home Diversion - Contact Form
	   Paraprofessional Contact Form
	
	(B) SELECT CANCEL

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: Security: Category: ECM Disenrollment Form Level 4 ▼ <Select> ▼ File: Select Template: Case: Browse... ECM Disenrollment Form 🔍 CM9436038 - ECM - Diabetes 🔍 ☐ This is a member interaction *(Checking this box will show additional fields)* Font ▼ Size ▼ Color ▼ **B** *I* <u>U</u> ≡ ≡ ≡ ≡

INSTRUCTIONS	SCREENSHOT
	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 **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).**
(A) 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 Reason**: **All care goals are met**= 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 member is ready to graduate from the program. **Member is ready to transition to a lower level**	![Molina Healthcare logo] 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.

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS	SCREENSHOT
of care= Member is ready to be downgraded to a lower level of care management, like CCM. **Complete a direct referral to Molina's CM prior to disenrolling the member from ECM.** **Member no longer wishes to receive ECM or is unwilling to engage**= Member does not want to be in the program or is unwilling to engage. This can include instances when a member's behavior or environment is unsafe for the ECM Provider. If the member no longer wants to be in the program, the ECM LCM is required to mail the Post Opt-In Decline Letter to the member. This can be mailed on the day the member is disenrolled. **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 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 country and doesn't know the member's return date, wait 30 days from the date of identification. If the member continues to be out of the country past 30 days, proceed with	**Enhanced Care Management (ECM) Disenrollment Form** Member Name [ ] * [ ] * Member Date of Birth [ ] 📅 * Medicaid ID [ ] * — **4** Date of Disenrollment [1/4/2022] 📅 * **A** — 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 **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).

INSTRUCTIONS	SCREENSHOT
disenrolling the member. <u>If the member cannot be contacted, the ECM LCM must mail the ECM Post Opt-In UTC Letter at least a week before planning to disenroll the member to give the member time to receive the letter and call back.</u> **Incarcerated=** Member has been incarcerated. Member is unable to receive services while incarcerated. **Member is 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. **Not enrolled with Molina Medi-Cal program**= The member is no longer eligible for Medi-Cal benefits through Molina Healthcare. Most times, the member leaves our plan and becomes restricted in	

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS	SCREENSHOT
CCA, if this happens, the ECM LCM is no longer able to submit the Disenrollment Form. **Switched Health Plans=**If the member switches health plans and is no longer eligible to receive services for ECM, they will need to be disenrolled. In some instances, the member will become restricted in CCA, and the ECM LCM will not be able to complete a disenrollment form. **Member moved out of the county=** The member no longer resides in the county. If they live in a county not serviced by any ECM Provider, they need to be disenrolled. **Member moved out of the country=** If member no longer resides in the country, they will need to be disenrolled from ECM, as they no longer qualify. **Unsafe behavior or environment=** If it is no longer a safe environment for the ECM LCM, a disenrollment form will need to be completed. **Member passed away**= The member has expired. (B) Using the free text field, input additional information based on the reason for the member's disenrollment. For example, if the ECM LCM is unable to mail the Post Opt-In UTC Letter or	

INSTRUCTIONS	SCREENSHOT
Post Opt-In Decline Letter to a member due to no address on record, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box.	
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). Save Spell Check Clear Content Cancel

ECM Checklists

Below are checklists that we put together to give our ECM Providers an idea of 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 our training materials for more information:

MIF Process Checklist
Initial MIF Process ☐ ECM Provider will provide MIF parameters to Molina ECM Team, as well as any MIF parameter changes ☐ Molina's ECM Team will send a secure email to the ECM Provider with their monthly MIF
ECM Provider reviews MIF and informs Molina's ECM Team: ☐ If there are any discrepancies with the MIF ☐ If they are unable to take on any members and need Molina's ECM Team to reassign the members to another ECM Provider
MIF Outreach Process ☐ ECM LCM will outreach the members in their MIF **within five business days** from the date of receipt of the MIF ☐ ECM LCM checks Availity before outreaching members from their MIF to ensure their members are still eligible with our Plan ☐ ECM LCM documents that Availity was checked by entering a Contact Form in CCA. *Purpose of Contact: ECM|Welcome.*

MHC Healthcare Services- Enhanced Care Management

MIF Process Checklist

- [ ] 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, evidencing completion of the Enrollment Assessment.

Member is UTC & Insufficient Contact Information

- [ ] ECM LCM will complete at least four non-mail attempts and mail the *ECM Generic UTC Letter* (for a total of five attempts). 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 two business days if they find alternate contact information.
- [ ] 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 the ECM Enrollment Assessment in CCA, follow prompts in the screen, and select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member was *Not Enrolled (Unable to Contact)* and documented the details of the UTC attempt in the Comment's box. A contact form should also be entered in CCA, evidencing completion of the Enrollment Assessment.
- [ ] Suppose the ECM LCM has insufficient contact information to continue outreach efforts. In that case, the ECM LCM will complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member was *Not Enrolled (Unable to Contact),* enter "*Yes*" under the question "Is the member unable to contact due to insufficient contact information" and document the details of the UTC outcome in the Comment's box (e.g., wrong phone number, address, etc.). A contact form should also be entered in CCA, evidencing completion of the Enrollment Assessment.

Member Declines Participation in ECM

- [ ] If the member declines participation in ECM, the ECM LCM will complete ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member *Declined* ECM and enter in comment's box member's reason for declining
- [ ] 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. The contact form should also be evidence that the Enrollment Assessment was completed.

Member is deceased

- [ ] If the ECM LCM is informed that the member passed away, the ECM Provider will complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member is *Deceased.*
- [ ] ECM LCM will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Deceased. The contact form should also be evidence that the Enrollment Assessment was completed.

Member meets some pre-identified Populations of Focus.

- [ ] If the member meets some of the pre-identified Populations of Focus, ECM Provider will complete the ECM Enrollment Assessment in CCA, follow the prompts in the screen, select "*Yes*" under the question "Did you discuss/ confirm eligibility for ECM," select "*ECM Eligible*" under the CM Referral Source, and indicate "Yes" under question (s) "Does member meet these criteria?," for the pre-identified Populations of Focus the member meets. For the Populations of Focus the members do not meet, indicate "No" for each "Does member meet these criteria?" pre-identified Population of Focus question(s) the member didn't meet.
- [ ] 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. The contact form should also be evidence that the Enrollment Assessment was completed.
- [ ] ECM Provider will refer to the next steps in the *"Enrollment Process Checklist."*

MHC Healthcare Services- Enhanced Care Management

MIF Process Checklist

☐ ECM Provider will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team Inbox. Molina's ECM Team will make changes in their system to reflect members' true Population(s) of Focus.

Member does not meet any Population of Focus.

☐ 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 complete the ECM Enrollment Assessment in CCA, follow prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "*ECM Eligible*" under the CM Referral Source, and indicate "No" under the question "Does member meet these criteria," for each pre-identified Population of Focus the member didn't meet.

☐ 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. The contact form should also be evidence that the Enrollment Assessment was completed.

☐ 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.

Member does not meet any pre-identified Population(s) of Focus, but meets other Population(s) of Focus

☐ If the ECM LCM identifies that the member *does not meet any* of the pre-identified Population(s) of Focus but meets other Population(s) of Focus, the ECM LCM will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team. Molina's ECM Team will make changes in their system to reflect member's true Population(s) of Focus.

☐ After making changes, Molina's ECM Team will inform the ECM LCM to proceed with enrolling the member by completing the Enrollment Assessment in CCA. The ECM LCM will complete the Enrollment Assessment in CCA, follow the prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "*ECM Eligible*" under the CM Referral Source, and will indicate "Yes" under the question "Does member meet these criteria," for each identified Population of Focus the member met.

☐ ECM LCM will refer to the next steps in the "*Enrollment Process Checklist.*"

Member meets some pre-identified Populations of Focus & meets other Population(s) of Focus.

☐ If the ECM LCM identifies that the member *meets some* pre-identified Population(s) of Focus and meets other Population(s) of Focus, the ECM Provider will proceed with enrolling the member by completing the ECM Enrollment Assessment in CCA, following prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "*ECM Eligible*" under the CM Referral Source, and will indicate "Yes" under question (s) "Does member meet these criteria?," for the pre-identified Populations of Focus the member meets. For the Populations of Focus the members do not meet, indicate "No" for each "Does member meet these criteria?" pre-identified Population of Focus question(s) the member didn't meet.

☐ ECM LCM will refer to the next steps in the *"Enrollment Process Checklist."*

☐ ECM LCM will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team Inbox. Molina's ECM Team will change their system to reflect members' true Population(s) of Focus.

Member is in a duplicative program.

☐ 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 complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "*ECM Eligible*" under the CM Referral Source, and indicate "Yes" under the corresponding question the addresses the duplicative program (e.g., state waiver program question, CCT question, hospice question, Molina CM question, etc.). The ECM

MHC Healthcare Services- Enhanced Care Management

MIF Process Checklist
LCM will also need to enter the name of the duplicative program under the "Describe the duplicative program" question.
☐ ECM LCM will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Successful Contact. The contact form should also be evidence that the Enrollment Assessment was completed.
Note: If a member is UTC or declines participation into ECM, a Disenrollment must not be completed.

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

Pre-enrollment (MIF Members)

☐ 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 <u>**five business days**</u> of enrolling a member

☐ ECM Provider and member agree on a follow-up date to complete the HRA and develop the care plan *(Best Practice: Complete the HRA within three business days from enrolling a member and complete the care plan within two business days of HRA completion, but no later than 90 days from enrollment date)*

☐ ECM Provider documents enrollment outreach via the Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact*

Pre-enrollment (Referred Members)

☐ Molina ECM Team will refer members to the ECM Provider and will request that the **ECM Provider** enroll the referred member via the ECM Enrollment Assessment in CCA within 24 hours.

☐ ECM Provider assigns an ECM Lead Care Manager (LCM) to the member within <u>**five business days**</u> of enrolling a member

☐ ECM Provider documents enrollment via the Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact*

☐ ECM LCM outreaches members within <u>***five business days***</u> 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 opted-in

☐ ECM Provider will review the Weekly 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 <u>**three business days**</u> 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 <u>**five business days**</u> 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 (HRA & Care Plan)

☐ ECM LCM checks Availity prior to engaging the member to ensure member is still eligible with our Plan

☐ 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 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 completes the HRA with the member, determines member's acuity, and develops the care plan *(no later than 90 days from enrollment date)*

☐ ECM LCM completes condition-specific assessments (if applicable) with the member and documents completion of the assessment(s) via the Contact Form in CCA

☐ 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 HRA 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.

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

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

- ☐ ECM care plan contains Problem, Goal, Intervention, Outcome, and Barrier
- ☐ ECM LCM conducts ICT with Clinical Consultant and discusses the member's CA-HRA and care plan. The Clinical Consultant provides input (as needed). ECM LCM documents on behalf of the Clinical Consultant their review via the Contact Form in CCA.
- ☐ ECM LCM **is required to obtain member consent** when developing the care plan and anytime the care plan is updated. This should always be documented in CCA's Care Plan and 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 _within 90 days of enrolling the_ member _(Best Practice: within three business days of completing the care plan)_
- ☐ ECM LCM documents the completion of the CA-HRA, discussion of care plan goals with the member, and notes member consent was obtained via the Contact Form in CCA. Purpose of Contact =_ECM|Assessment|Care Plan Development / Revision (if both the HRA and Care Plan were completed on the same day)_
- ☐ Depending on member needs, the ECM LCM should also administer condition-specific assessments. If the PHQ-9 or PTSD 5 assessments were administered, the ECM LCM will need to mail Molina's ECM PHQ-9 PCP Notification Letter and PTSD 5 PCP Letter to the member's PCP. These letters are not found in CCA. Molina's ECM Team has provided the templates.
- ☐ ECM LCM will set a reminder to complete the HRA Reassessment within six months from the initial HRA completion date. ECM LCM sets reminders to follow up with the member to continue to provide ECM services every month

- ☐ If a member requested the Advance Directives booklet during the completion of the CA-HRA 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 HRA & Care Plan)
- ☐ ECM LCMs will engage members every month and provide ECM services; this includes educating/coaching the member and utilizing Healthwise Knowledge Base (available in CCA)
- ☐ ECM LCM will refer members to services such as community support services, LTSS, IHSS, etc., as applicable
- ☐ ECM LCM will continue to check Availity before engaging the member to ensure the member is still eligible with our Plan
- ☐ 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. 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 six (6) months at a minimum from the last update or more frequently upon changes in the member's health status or condition.
- ☐ ECM Provider will continue to administer CA HRAs (reassessments), condition-specific assessments (as needed), and Transitions of Care Assessments
- ☐ 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 for a lower level of care.

Case Conferences (ICT Meetings)
- ☐ ECM LCM will conduct and participate in case conferences to help ensure that the member's care is continuous and integrated among all service providers. A case conference will need to occur within 60 days of identified need, dependent on the acuity of the situation.
- ☐ ECM LCM will report all ICT meetings via the Contact Form in CCA. _Purpose of Contact: ECM|ICT Meeting_

NAL & BH Crisis Follow-Ups
- ☐ Molina ECM Team will inform ECM Providers if we identify a member who called the Nurse Advise Line (NAL) or the BH Crisis Line.

Enrollment Process Checklist
Enrollment into ECM (Successful Engagement)

- [ ] ECM LCM will need to follow up with the member within 24-48 hours from the date of notification and assist 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 Provider will review the Daily IP Census Report (outbound by Molina via the sftp site) for any members who have been hospitalized or in an SNF. The report will include MIF members and members who have been enrolled in ECM. *For MIF members, use this report to outreach members in the hospital/SNF for enrollment into ECM.*
- [ ] When available, Molina ECM Team will also notify the ECM Provider if a member has been hospitalized.
- [ ] ECM LCM must use all tools at their disposal to identify and interact with recently admitted/discharged members
- [ ] ECM LCM will follow up with the member via telephone within two business days of discharge to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist.
- [ ] ECM LCM will conduct a face-to-face visit within seven business days from discharge to determine the member's post-inpatient status and any further care needs and complete the Transition of Care assessment
- [ ] ECM LCM is expected to collaborate, communicate, and coordinate with all involved parties.
- [ ] ECM LCM will complete a new HRA with the member, and the care plan should be updated post-discharge to address hospitalization and measures to prevent readmission. ECM LCM should discuss the updated care plan with their clinical consultant for input (as needed)
- [ ] ECM Provider will report completed a new CA-HRA (*HRA Reassessment)*
- [ ] ECM LCM will discuss the updated care plan with the member and obtain the member's consent
- [ ] ECM LCM will mail a copy of the revised Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the revised care plan to the member's PCP along with the PCP ECM Care Plan letter within 14 business days of updating the care plan *(Best Practice: 3 business days of updating the care plan)*
- [ ] 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.
- [ ] ECM LCM will complete a Transitions of Care (TOC) Assessment with the member within seven business days after the member has been discharged from the hospital/SNF.
- [ ] ECM Provider will document all TOC-related outreaches via the Contact Form in CCA. *Purpose of Contact: ECM|Post Discharge Outreach| Assessment|Care Plan Development/ Revision|Coordination of Services*

HRA Reassessments

- [ ] ECM LCM will complete a new CA-HRA (HRA Reassessment) within six months from the initial CA-HRA completion date (& every six months thereafter). Members might require a new CA-HRA to be completed sooner if they are hospitalized.
- [ ] ECM LCM will revise the care plan if there's a change in a member's condition and discuss the updated care plan with their clinical consultant for input (as needed).
- [ ] ECM LCM will discuss the updated care plan with the member and obtain the member's consent.
- [ ] ECM LCM will mail a copy of the revised Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the revised care plan to the member's PCP along with the PCP ECM Care Plan letter within 14 business days of updating the care plan *(Best Practice: 3 business days of updating the care plan).*
- [ ] ECM Provider will document all HRA and Care Plan outreaches via the Contact Form in CCA. *Purpose of Contact: ECM| Assessment|Care Plan Development/ Revision.*

Medi-Cal SPD Members

- [ ] If an existing Medi-Cal member changes product lines and is designated as "Seniors and Persons with Disabilities (SPD)," a new HRA must be completed within 30 days of the member's enrollment as SPD. The Molina ECM Team will send reminders as the due date approaches.
- [ ] ECM LCM will follow the same steps for completing the CA-HRA and updating the care plan

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
☐ If an ECM member has a complaint/grievance, the ECM LCM should educate/assist the member with filing the grievance (please act on this as soon as you identify it).
☐ For more information on filing a grievance, please review the latest Member Handbook on the Molina Website. The 2023 Member Handbook is located below: https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2023-English-Spanish-EOC.pdf
☐ Member services will route the grievance to the Appeals & Grievance Team.
☐ The Appeals & Grievance Team will review and route the grievance to Molina's ECM Team to request information.
☐ Molina's ECM Team will provide member's assigned ECM LCM contact information to the Appeals & Grievance Team (based on ECM LCM information entered in the CCA Address Book)
☐ Molina's ECM Team will route the *Grievance Response Form* to the assigned ECM Provider and give them 48-72 hours to respond to the questions in the form. *Keep in mind even if the grievance is not against the ECM Provider, the Appeals & Grievance Team will still want to gather information from the assigned ECM Provider.*
☐ Depending on the grievance, the ECM LCM might need to make another outreach to the member and document the outcome in CCA via the contact form.
☐ ECM Provider will submit their completed Grievance Response Form to Molina's ECM Team.
☐ Molina's ECM Team will review the Grievance Response Form and route it to the Appeals & Grievance Team.
☐ The Appeals & Grievance Team will review and might ask for updates and/or additional information.
☐ The Appeals & Grievance Team might also contact the assigned ECM LCM for information.
☐ Molina's ECM Team will contact the ECM Provider and request an update and/or additional information.
☐ The requested information will be routed to the Appeals & Grievance Team.
☐ The Appeals & Grievance Team will mail a resolution letter to the member and include the assigned ECM LCM's contact information.

MHC Healthcare Services- Enhanced Care Management

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.

Disenrollment Process

UTC Members

☐ 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.

☐ 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.

☐ 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

☐ 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

☐ 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 declined ECM

☐ 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 Template* 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.

☐ 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.

☐ 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

☐ 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.

MHC Healthcare Services- Enhanced Care Management

Disenrollment Process

☐ 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 Template* 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, 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:*

        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

MHC Healthcare Services- Enhanced Care Management

Disenrollment Process

☐ 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.

☐ 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.

MHC Healthcare Services- Enhanced Care Management

Disenrollment Process

☐ 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:*

   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_ECM@MolinaHealthCare.Com. Molina's ECM Team will contact you with the next steps.

MHC Healthcare Services- Enhanced Care Management

Molina ECM Reports

Below is a list of all the reports that Molina's ECM Team provides to 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 on a quarterly basis.	Excel File	Manually via email	Quarterly
MIF Eligibility File (aka TEL)	List of ECM Eligible members assigned to each ECM Provider. For use in outreach and enrollment.	Excel file	Manually via secure email	Monthly
Member Activity Report	Post opt-in ECM activity by the member. Includes most recent contact date; HRA completion date; ICP due date; assigned ECM Lead CM. Refer to the report for all fields. ECM Providers must review this report as part of their oversight and monitoring activities and reconcile against capitation reports.	Excel file	sFTP	Daily
IP Census Report	ECM Eligible & Opt-in members who are currently inpatient (Hospital & SNF). Utilize this report in addition to an email notification from Molina for transition of care (ToC) activities	Excel file	sFTP	Daily
HEDIS/Gaps in Care Report	Preventative care measures. ECM LCM is to educate the member on the importance of preventative care, discuss details of missing HEDIS/ Gaps in Care measure, and assist member with care coordination to help remove potential barriers. Report should align with CCA Alerts and Member Dashboard Care Gaps section.	Excel file	sFTP	1st of the Month
Monthly Capitation Details	Cap reports with member details are available through the Financial Exchange Services (FES) portal. Reports are available within one day of the capitation payment being generated.	Excel	FES	Monthly

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

MHC Healthcare Services- Enhanced Care Management

ECM Payment Information

The File Exchange Services (FES) Portal provides capitation payment reports with member-level details available through the FES portal. Reports are available within one day of the capitation payment being generated.

If your organization needs access to FES, please email the name, organization, and email of each person requesting FES access to the ECM team: MHC_ECM@MolinaHealthcare.com. We recommend each organization requests access for at least two employees: one person from your Finance/Accounting Department and one person from your ECM team. Upon being granted access, users will receive an email with the FES login and password. Access FES at the following link: https://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.
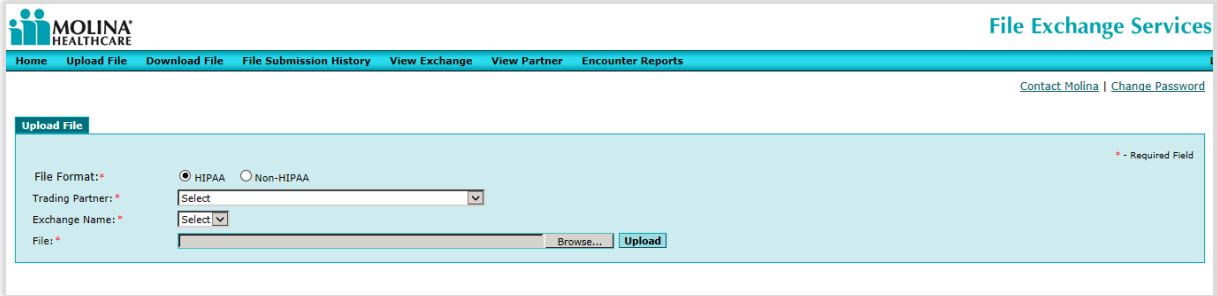
INSTRUCTIONS

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.
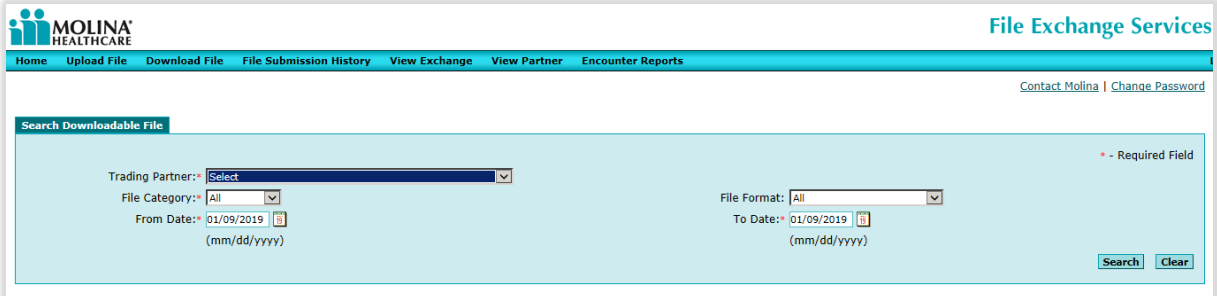
Select the file format, Trading Partner and Exchange Name. Then select the file to be uploaded and click on upload.

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

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS

- From Date
- To Date

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

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

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS

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

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

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS

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.

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

MHC Healthcare Services- Enhanced Care Management

INSTRUCTIONS

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.

MHC Healthcare Services- Enhanced Care Management