

Enhanced Care Management Provider Manual

Part 1

Molina Healthcare of California

(Molina Healthcare or Molina)

2025

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

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MOLINA® HEALTHCARE

Enhanced Care Management Provider Manual

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

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

Thank you for your partnership and service to our members!

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Enhanced Care Management | Overview and Requirements

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems (*DHCS ECM Policy Guide, page 5, II. What is Enhanced Care Management*). ECM is a statewide Medi-Cal benefit offered at no cost to all eligible Medi-Cal members as defined by the DHCS ECM Policy Guide.

Population of Focus

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

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

Goals

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

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

Services

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

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

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

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

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

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

ECM Provider Roles and Responsibilities

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

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

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

ECM provider responsibilities include:

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

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

Care Management Documentation System Requirements

Per the DHCS ECM Policy Guide, ECM Providers are required to use a care management documentation system or process that meets the following requirements:

- Supports the documentation and integration of physical, behavioral, social service and administrative data and information from other entities to support the management and maintenance of a Member Care Plan.
- Ability to share the Member care plan with other Providers and organizations involved in each Member's care.
- May include Certified Electronic Health Record (EHR) Technology, or other documentation tools that can:
    - Document Member goals and goals attainment status.
    - Develop and assign care team tasks.
    - Define and support Member care coordination and care management needs.
    - Gather information from other sources to identify Member needs and support care team coordination and communication.
    - Support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

The care management documentation system must be able to show evidence of:

- System generated date/timestamp of care management activities as records are subject to audit.
- The member's full name and CIN or date of birth.
- Full name/title of ECM staff who conducted the outreach (pre-enrollment) or contact/attempt (post-enrollment), as well as identifying if the ECM staff is clinical or non-clinical.
- Entered in system **no later than** 30 days from date of outreach or contact/attempt. If unable to enter timely (e.g. system issue/outage) reason is indicated in system.
- Outreach or contact/attempt dates.
- Respondent(s): who you intended to reach.
- Outcome of outreach or contact/attempt: indicate if it was successful, or left message, or requested a later call, or invalided phone #/disconnected, or refused to speak, or requested no further contact, or no answer, or member deceased, or completed research, or any other outcome.
- Notes explaining purpose of outreach or contact/attempt and the outcome of it.
- Outreach or contact/attempt direction: Outbound or inbound. Outbound, you reached out to the member. Inbound, the member reached out to you.
- Outreach or contact/attempt method: in-person at member's home, a facility, PCP office, or phone call, or left voicemail, or text, or mail, or email/internet, or fax, or tele-visit, or any other method (explain).

- HIPAA Identity/Authorization Verification: When you speak to the member or speak to someone on behalf of the member, you must verify HIPAA. Verification should include at minimum two of the following:
    - Member's address
    - Member's date of birth
    - Member's CIN
    - N/A (Member is unable to contact)- You were not able to verify because you didn't get a hold of the member.
- Length of outreach or contact/attempt (e.g., 30 minutes).
- Assessments
- Copy of ECM letters mailed to member and member's PCP (as applicable), indicate in notes which letters were mailed, and dates they were mailed, if unable to mail letters reason needs to be indicated.

In addition to documenting each outreach and contact/attempt, the ECM Provider must also document any activity that was completed on behalf of the member or for the member, including pre-call reviews/research.

Contracted ECM Providers have the option to use Molina's care management system, Clinical Care Advance (CCA) or to utilize their own care management system/EHR to meet the requirements specified above. Molina does not require that contracted ECM Providers document in CCA.

Molina refers to contracted ECM Providers who choose to document in their own EHR as **Non-CCA Users**. Non-CCA Users are required to exchange data via the Outreach Transmission File (OTF) and the Return Transmission File (RTF) to meet DHCS requirements for data exchange and reporting. Refer to the OTF/RTF Training in the **Attachments** section for more information. In addition, the ECM Provider's EHR is subject to regulatory and internal audits to ensure program and contract compliance.

Please refer to the latest DHCS ECM Policy Guide regarding care management documentation requirements.

Outreach and Engagement

ECM Eligible Membership | Member Referrals and MIF

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

Additionally, MCPs are responsible to proactively identify members who may benefit from ECM and meet the criteria for the PoFs based on available data sources. The file that is generated from this process is called the Member Information File (MIF).

Member Referrals:

Molina applies a "No Wrong Door" policy for referrals to ECM. Network providers, including PCPs, specialists, hospitals, etc. may refer members to ECM. Members may self-refer or be referred by their representative, parents, caregiver or legal guardian.

Molina's ECM referral form is found on the public website, under Frequently Used Forms: Frequently Used Forms (molinahealthcare.com). Molina will also accept universal referral forms and forms from other MCPs.

Referral Submission Guidelines:

- To be eligible for ECM, members must be enrolled in Medi-Cal Managed Care with Molina, meet criteria for one or more of the identified ECM PoFs, without hold restrictions, and must not be enrolled in exclusionary programs or receiving duplicative services.
- The completed ECM Member Referral Form must be submitted via secure email to the Molina ECM team: MHC_ECMReferrals@molinahealthcare.com with subject line as follows: *"<Expedited>/<Routine> ECM Referral – QTY <Insert # of Referrals in the request> - Member Initials - <Name of Organization>"*
- To expedite the review and approval process, please also submit applicable supporting documentation as evidence of the members meeting ECM criteria.
- The Molina ECM team will review to verify the member's eligibility and respond within five (5) business days of receipt of the request to the requestor.
- Please submit no more than five (5) referrals in one email. This will ensure that referrals are processed more timely, as multiple ECM team members work on referral processing.
- Expedited referrals:
    - Members who are currently in the hospital and meet PoF criteria, who are in need of urgent care coordination through an ECM Lead Care Manager within 72 hours.
    - Members who have a condition that requires outreach and care coordination through an ECM Lead Care Manager within 72 hours.

Newly Assigned Members through an ECM Referral

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

Presumptive Authorization Referrals

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

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

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

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

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

- If the referred member is already opted-in and assigned to/receiving services from another ECM provider, the referral will be cancelled to prevent disruption in care. In this instance, the member must request the ECM provider change by contacting Member Services at (888) 665-4621, Monday through Friday, from 7 AM to 7 PM. The Member

Services team will notify the ECM team of this request and the change will take effect the first of the following month.

- Please note that members identified in the community may already be identified through the MIF process and assigned to another ECM provider, who is in the process of outreach. Please verify with the member if anyone has contacted them for ECM as outreach cannot be billed and reimbursed for multiple providers for the same member.
- If the ECM provider has already been providing ECM services to the member prior to referral, the ECM Provider must notify Molina's ECM Team if the referral needs to be backdated to the date the member became ECM Eligible due to impacts to the payment and the data exchange process. The ECM Benefit Start Date/ECM Opt-In Date must be after the date the member was identified to be ECM Eligible. This date should match the ECM Provider's documentation of a member's verbal &/or written consent into ECM within the ECM Provider's care management documentation system. Refer to your organization's Member Activity Report and/or MIF for ECM Benefit Start Date/ECM Opt-In date for members who are already enrolled in ECM.

Member Information File (MIF)

Molina leverages various data sources to generate the MIF File, which contains a list of members who are identified as meeting the criteria for one or more ECM PoF. Members included in this file that are identified by Molina are considered auto-approved for ECM services based on presumptive eligibility, and can be enrolled into the program without any additional authorization, upon confirmation of member eligibility and member consent.

Newly ECM-Eligible MIF and Referred Members

ECM Providers must outreach to all their newly eligible members within five (5) business days of receipt of the MIF or date of referral notification. ECM Providers are eligible for separate reimbursement for up to five (5) outreach attempts for the purposes of enrolling a member into the ECM program.

- Outreach must be initiated within five (5) days of receipt of the MIF or date of referral notification and the minimum required outreaches completed within sixty (60) calendar days.
- Attempts should be made on different days and times using at least three different modalities (in-person, phone, email, and text).
- ECM providers must have evidence of at least **four attempts (non-mail attempts)** and **mail the ECM Generic Unable to Contact (UTC) letter** (for a total of five attempts) for members who are unable to be reached.
    - If the member is unable to be contacted (UTC) at any point prior to or after enrollment, ECM Providers are required to research alternate contact information, such as reviewing any available information, including calling the member's PCP or pharmacy, admission/discharge information, direct referral to the Member Location Unit, etc.). Outreach attempts should be documented in the ECM Provider's EHR, indicating appropriate outcome and correct UTC letter sent.

Direct Referral to Molina's Member Location Unit

ECM Providers can send a direct referral to the Molina Member Location Unit for help in alternate contact information for UTC members or members without sufficient contact information. The ECM Tasking Template (template found in the **Attachments** section) needs to be completed and emailed to CMescalationCA@MolinaHealthcare.com. The completed form will be routed to Molina's Member Location Unit for assistance in finding alternate contact information. If your organization does not hear from Molina's Member Location Unit within two weeks of emailing the form, you can assume they were unable to find alternate contact information and can proceed with either disenrolling the member (for those UTC post Opt-In) or discontinuing further outreach (for those members not enrolled). If they are able to find alternate contact information, they will email the requestor and provide the member's information no later than two weeks from the date the direct referral form was emailed.

Outreach Script

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

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

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

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

We can help with:

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

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

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

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

Would you like me to meet you at this address?

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

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

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

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

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

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

Final Outreach Outcome| ECM Enrollment

Regardless of the outcome, the ECM Provider must document all outreach attempts in their EHR. Refer to **Care Management Documentation System Requirements** section above for outreach documentation requirements. In addition, if the ECM Provider has exhausted outreach attempts and was unable to enroll the member into ECM, their EHR documentation should also reflect final outcome.

Discontinuation Reasons| Final Outreach

Below is the complete list of discontinuation reasons and descriptions. ECM Providers must indicate in the RTF the discontinuation reason code for members they were unable to enroll into the program, along with the Recommended for Discontinuation Date:

- **Unable to contact after exhausting minimum required attempts/Insufficient contact information** (discontinuation reason code 4 in RTF**)** = The ECM Provider exhausted the minimum required attempts, and the member is unable to be contacted, or the ECM Provider does not have sufficient contact information to get a hold of the member.
- **Member Incarcerated** (discontinuation reason code 5 in RTF**)** = The member is incarcerated.
- **Member declined participation into ECM** (discontinuation reason code 6 in RTF**)** = The member declines to enroll into the ECM Program.
- **Member is enrolled in a duplicative program** (discontinuation reason code 7 in RTF**)** = ECM Provider identifies that the member is receiving duplicative services from another DHCS-approved program. In some cases, the member may choose to enroll in the ECM and opt-out of the other program, 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.
- **Member lost Medi-Cal coverage** (discontinuation reason code 8 in RTF**)** = The member is no longer eligible for Medi-Cal benefits through Molina Healthcare.
- **Member switched health plans** (discontinuation reason code 9 in RTF**)** = The member switched health plans.
- **Member moved out of the county** (discontinuation reason code 10 in RTF**)** = The member no longer resides in a county where Molina contracts (Molina contracts in: Los Angeles, Riverside, Sacramento, San Bernardino, and San Diego). For members who switch counties, and your organization does not contract in that county, notify Molina's ECM Team and the member will be reassigned to an ECM Provider who contracts in the member's county.
- **Member moved out of the country** (discontinuation reason code 11 in RTF**)** = The member no longer resides in the country.

- **Unsafe behavior or environment** (discontinuation reason code 12 in RTF**)** = The member is exhibiting unsafe behavior or environment is no longer safe for the ECM Provider.
- **Member deceased** (discontinuation reason code 14 in RTF**)** = The member has expired.
- **Member did not qualify for at least one Population of Focus** (discontinuation reason code 15 in RTF**)** = The member does not qualify for at least one Population of Focus.

Members might not qualify for ECM due to being enrolled in a duplicative program. Such duplicative programs might include HIV/AIDS, Assisted Living Waiver, Developmentally Disabled, Multipurpose Senior Services Program, Home and Community-Based Alternatives, California Community Transitions (CCT), Hospice, and Molina CM. Refer to the latest DHCS ECM Policy Guide for more information on exclusionary criteria and to **ECM Exclusions and Other State Programs/Benefits | Non-Duplication** section above for more information.

ECM Enrollment

If an ECM Provider successfully contacts a member for enrollment into ECM, the ECM Provider must review the ECM Program Eligibility and Populations of Focus with the member. If outreach lead to enrollment, the ECM Provider's EHR should also identify member's date of enrollment, respondent (if different from member), program discussion notes, population(s) of focus member qualifies, program overlaps and exclusions discussed, member's confirmation of ECM provider assignment, who consented (e.g., member, Child/Youth member, parent, guardian, caregiver, Department of Children and Family Services, Court, or Foster Parent(s), type of consent (verbal or written), and confirmation that member or member's representative provided verbal agreement for data sharing related to care coordination through ECM.

Closed-Loop Referrals

Closed-Loop Referrals (CLR) are a key component of DHCS's Population Health Management Program under CalAIM. DHCS defines a Closed-Loop Referral (CLR) as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure. A Known Closure occurs when a member's initial referral loop is completed with a Known Closure reason such as the member receiving services. The goal of CLRs is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability. The CLR requirements aim to improve MCP information collection, supportive actions on individual referrals, and system -level improvements that will result in Members being connected more quickly to priority services for their health and well-being. MCPs and ECM Providers are required to implement CLR requirements starting July 1, 2025.

CLR Requirements

ECM Providers are required to report the referral status and the referral status date for each member assigned to them, as well as the reason for referral closure and referral closure date via the monthly RTF. A referral status will indicate where the member is in the Closed-Loop Referral Process and is needed for each member assigned to your organization. The goal is to ensure the ECM Provider has closed loop on each member referral. ECM Providers are required

to provide the latest Referral Status as of the end of the reporting month in their RTF. Molina's ECM Team will review this information and follow up with ECM Providers to ensure compliance with CLR requirements. The updates shared in the RTF are submitted to DHCS on a monthly cadence in accordance with regulatory reporting, this is why it's imperative for ECM Providers to submit their data accurately and timely. Failure to comply with CLR requirements may result in issuance of a Corrective Action Plan (CAP), freeze on member referrals, member reassignments, and even contract termination. Below are the four (4) referral statuses and requirements:

1. **Pending**- your organization has not decided if they will accept the member referral or if they will be declining it. If this is the case, you will report *(3) Pending* in the **Referral Status** column and will enter the date the member was assigned to your organization under the **Date of Referral Status** column. The date the member was assigned to your organization is found in the MIF. Your organization must decide within three (3) business days of receiving the member referral from Molina's ECM Team if they are accepting or declining the member referral. A member should not have a *(3) Pending* status no more than (3) business days. **Note**: If you are accepting a member referral, you are required to complete initial outreach within five (5) business days of receiving the member referral.
2. **Accepted**- your organization accepted the member referral and plans to conduct outreach. If this is the case, you will report *(1) Accepted* in the **Referral Status** column and will enter the date your organization accepted the member referral under the **Date of Referral Status** column. Please note, your organization must complete initial outreach within five (5) business days of receiving the member referral from Molina's ECM Team, this means a member should not have an *(1) Accepted* status no more than four (4) business days.
3. **Outreach initiated-** your organization completed initial outreach within five (5) business days of receiving the member referral from Molina's ECM Team. If this is the case, you will report *(4) Outreach initiated* in the **Referral Status** column and will enter the date your organization conducted initial outreach under the **Date of Referral Status** column. Molina requires a total of five (5) outreach attempts to be completed within sixty (60) calendar days of your organization receiving the member referral, this means a member should not have an *(4) Outreach initiated* status no more than (60) calendar days. Report *(4) Outreach initiated* referral status until you've exhausted all outreach attempts, and the same date you completed initial outreach in the **Date of Referral Status** column. **Note**: Once you indicate *(4) Outreach* initiated in the RTF, you will not be able to change the referral status in future submissions to *(3) Pending* or *(1) Accepted*.
4. **Referral Loop Closed**- your organization has closed-loop on the member referral because of one of the following reasons:
    (1) Services Received- member was enrolled in ECM. Enter the ECM Benefit Start Date in the **Date of Referral Status** column.
    (2) Service Provider Declined-The ECM Provider declined referral due to being at max capacity or is unable to serve member's Population(s) of Focus, or declined due to member being outside their service area, or member presented unsafe

behavior or environment for the ECM Provider's staff. Enter the date the ECM Provider declined the member referral in the **Date of Referral Status** column.

(3) Unable to Reach Member-The ECM Provider exhausted the 5 minimum required outreach attempts and was not able to enroll the member in ECM because the member was unable to contact (UTC), or the ECM Provider had insufficient contact information to outreach the member, enter the last outreach attempt date or if the ECM Provider has insufficient contact information to outreach the member, enter the date this was identified in the **Date of Referral Status** column.

(4) Member No Longer Eligible for Services- The ECM Provider was not able to enroll the member in ECM because the member is no longer eligible for services. Enter the date you identified or was made aware of one of the following close loop referral reasons in the **Date of Referral Status** column.

- Member is deceased
- Incarcerated
- Duplicative program- Programs include CA EAE DSNP Plan, Non-EAE DSNP Plan, CCM, Hospice, etc. ECM Provider must verify if a member changed to CA EAE DSNP plan or Non-EAE DSNP plan by checking Molina's Availity Portal prior to outreach.
- Lost Medi-Cal coverage- ECM Provider must verify this information by checking Availity prior to outreach.
- Switched health plans- ECM Provider may be able to verify if a member is no longer with Molina Healthcare by checking Molina's Availity Portal prior to outreach.
- Moved out of the county
- Moved out of country- ECM Provider may be able to verify if a member is no longer with Molina Healthcare by checking Molina's Availity Portal prior to outreach.
- Member does not qualify for at least one Population of Focus

(5) Member No Longer Needs Services or Declines Services- The ECM Provider was not able to enroll the member in ECM because the member declined to enroll. Enter the date the member declined to enroll in the ECM Program in the **Date of Referral Status** column.

Refer to the latest OTF/RTF Data Dictionary, CLR Status Mapping, and RTF Template for additional information and instructions.

ECM Outreach Reporting, Billing and Reimbursement

- ECM Providers should bill ECM Outreach via claims following the normal billing process and using the ECM Outreach code/modifier combination per DHCS Billing/Coding guide.
- Claims can be submitted using the Availity portal or utilize the ECM Provider's normal claims submission process.
- The reimbursement is a fixed amount per diem, as communicated by the Molina Contracting team. This means that regardless of the number of units billed, the maximum allowable per date of service is equal to the agreed upon flat rate. ECM Providers are able to outreach as many times as needed or deemed necessary to enroll a member into the program. However, only a maximum of five (5) attempts are reimbursable per member.
- Reimbursement is only provided for members who are actively enrolled with Molina Medi-Cal for the date of service.

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

Reporting Referred and MIF Member ECM Status

Indicate the ECM status of members who have been referred into Molina's ECM Program and MIF members who are assigned to your organization in the OTF/RTF submissions.

Do not report members who have not been assigned to your organization, member record will be rejected.

In the OTF, include potential ECM Members (outreaches towards member enrollment) regardless, if the outreach was successful or not (NOTE: do not include outreaches made to members who are already enrolled) for your assigned member.

In the RTF, report all members assigned to your organization, whether they were enrolled or not.

OTF/RTF Requirements

- ECM Providers are required to submit the OTF/RTF to Molina via sFTP on a monthly basis, by the 5th of the month. If the due date lands on a weekend or holiday, submit the file the following business day.
- Please reference the OTF/RTF section in the **Attachments** section of this manual for detailed instructions.