

Enhanced Care Management Provider Manual

Part 3

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 Coordination of Care

Enhanced Coordination of Care includes the services necessary to implement the care plan. Enhanced Coordination of Care services must include, but are not limited to:

- Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan.
- Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs. Further, in alignment with the PHM BPHM requirements, the assigned ECM LCM is responsible for ensuring that the Member has an assigned PCP and that they are engaging with that PCP for appropriate care. Enhanced Coordination of Care may include case conferences in order to ensure that the Member's care is continuous and integrated among all service Providers.
- Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.
- Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
- Communicating the Member's needs and preferences in a timely manner to the Member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.
- Ensuring regular contact with the Member (and/or their parent, caregiver, guardian) when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the Member's conditions, health status, care planning, medications usages and side effects.

Post-enrollment Contacts & Attempts

ECM Providers are required to provide ECM services every month to our members.

- Documentation should reflect the development and member consent of a schedule to timely follow-up/communicate with the member to monitor progress and compliance with case management plans and goals and is modified based on the member's identified needs.
- As outlined in **Part 1: Case Management Documentation System Requirements**, contacts/attempts should consist of varying modes of contact and at different times of the day.

- ECM Providers are required to document ongoing care management of the member's needs in their EHR.
- All contacts/attempts made, regardless of the outcome, need to be documented in the ECM Provider's EHR. This includes date of contact/attempt, contact/attempt respondent, who performed the contact/attempt, time spent performing contact/attempt (length), contact method, contact direction (inbound or outbound), and the purpose of the contact/attempt (care coordination for the different services the member needs) along with the outcome of each outreach/contact with clear notes. (e.g., coordination for medication/DME needs, scheduling of appointments, appointment reminders, accompaniment to appointments, supply of health management education materials, coordination of transportation, assistance to SDOH needs, strategies to address avoidable admissions), etc.
- If a situation arises that requires the ECM LCM or anyone from their team to report a situation to the appropriate authorities, this should be evidenced in the ECM Provider's EHR.

For enrolled members who are later identified to be unable to contact, ECM Providers are required to complete at a minimum three non-mail attempts and one mail attempt (mail the ECM Post-Opt in UTC letter) for a total of **four attempts within the same month**. If the member continues to be unable to contact at the end of the month, our ECM Providers will extend their attempts to the next month.

We understand the challenges with contacting these members. If the member continues to be UTC by the end of the 2nd month, proceed with disenrolling the member no later than the **last day of the 2nd month**. See the example below:

I. *Member was enrolled on 1/1/2025.*
II. *ECM LCM attempts to contact the member on 1/9/2025, 1/17/2025, and 1/21/2025, and the member is unable to contact during all three outreaches.*
III. *ECM LCM mails the ECM Post-Opt in UTC letter on 1/24/2025 to address on record.*
IV. *Member does not contact ECM LCM within a week of a letter being mailed.*
V. *ECM LCM attempts to contact the member on 2/3/2025, 2/11/2025, and 2/14/2025, 2/21/2025 (4th attempt needs to be a UTC Letter), and the member is unable to contact during all four outreaches.*
VI. *ECM LCM proceeds with disenrolling the member on 2/28/2025.*

Refer to the **Part 1: Outreach and Engagement** section of this manual for outreach requirements for newly ECM-Eligible MIF members and referred members.

Monthly Capitation

Capitation will start after Molina receives the ECM Provider's RTF data. This data will get ingested into Molina's CCA system and based on the information provided in the RTF, will trigger payment for enrolled members.

- Refer to the OTF/RTF Training in the **Attachments** section for more information on the fields that Molina leverages in the RTF to pay ECM Providers.
- Molina's Finance Team runs cap on the 15th of the month, ECM Providers will receive payment thereafter.
- If a provider was able to enroll a member into ECM, the ECM Provider will receive payment for the month the member was enrolled.
- Payment post-enrollment depends on the ECM Provider providing continuous monthly ECM services, and complete and accurate data in the RTF.
- ECM Providers will receive payment for providing service and/or interactions with the member and on behalf of the member, regardless of the outcome of the contact.
- ECM Providers will not receive capitation for months they do not provide ECM services.

Encounters

DHCS reviews ECM encounter data submitted by Managed Care Plans (MCPs) to monitor program performance and integrity, and to better understand the health and service needs of Medi-Cal enrollees. As established in the ECM and Community Supports Billing and Invoicing Guidance, ECM Providers are required to submit encounter data for all ECM services provided to their members, including member encounters for denied presumptive authorizations. ECM Providers must ensure timely submission of ECM member encounters to Molina Healthcare.

Complex Case Management

A member cannot be enrolled in ECM and Complex Case Management (CCM) at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM.

Direct Referral to Molina's Case Management

If at any point your organization identifies that a member needs to be downgraded to a lower level of care (either during pre-enrollment or post-enrollment), the ECM Provider can submit a direct referral to Molina's Case Management Team by completing the Case Management Referral Form: **Case Management Referral Form (molinahealthcare.com)**.

- If the ECM LCM is disenrolling a member because the member is ready to transition to a lower level of care, the ECM LCM is expected to warm handoff the member to Molina's CM Department within 5 business days of referring the member. The ECM LCM should reach out to Molina's ECM Team to coordinate a warm handoff.
- Molina's CM Department may also refer members who would benefit from enrolling in our ECM Program and will reach out to the member's assigned ECM Provider to coordinate a warm hand off.

Privacy Breach

ECM Providers are not permitted to outreach members who are assigned to other ECM Providers or provide ECM services to enrolled members who are assigned to other ECM Providers. If ECM Providers are outreaching these members or providing ECM services to members not assigned to their organization, this is considered a privacy breach and will not be reimbursed. For ECM Providers with access to Molina's CCA care management system, it is also considered a privacy breach to look-up members not assigned to their organization.

Availity

ECM Providers are required to check member eligibility through Molina's Availity (Provider Portal) prior to member encounter (pre-enrollment and post-enrollment) to ensure the member continues to be enrolled with our plan, a Medi-Cal beneficiary, without hold restrictions, and current ECM status. In addition, prior to submitting any referrals to our ECM Team, ECM Providers are required to check the member's eligibility in Availity; this will avoid denying referrals for members not enrolled with Molina Medi-Cal.

ECM Providers can check the member's current ECM status by looking-up the member in Availity. Under "Service Level Contact Information," it will indicate "Member ECM Opt-In" (yes or no) and the member's assigned ECM Provider. Failure to check member eligibility may result in the ECM Provider not receiving payment for members who are no longer with our plan or withhold restrictions or no longer with Medi-Cal Benefit. Documentation should reflect when Availity was checked, what was the outcome of the review, and date it was reviewed.

For access to Availity, your organization's administrator (refer to your leadership) should register on: availity.com/molinahealthcare. If your organization's administrator is experiencing issues registering or needs training, please connect with your county's PSRs (refer to the Provider Quick Reference Guide Molina's ECM Team emailed).

Pre-Call Review

A pre-call review is a research exercise that the member's assigned ECM LCM needs to conduct every month (post-enrollment) to help with detecting any new patterns of care and should be addressed during care planning.

- The ECM LCM is required to complete a pre-call review **post-enrollment** and document it in their EHR at a minimum of once a month prior to a member encounter. This pre-call review exercise includes checking member eligibility in Availity, the HEDIS/Gaps in Care Report, the Member Activity Report (both reports provided via SFTP Site), and any available member data. The ECM Provider's EHR should clearly indicate date the pre-call review was conducted, as well as items reviewed, and action(s) taken.
- ECM Providers are required to review the HEDIS/Gaps in Care Report as part of the pre-call review exercise. This report is provided every 1st of the month via the sftp site. These HEDIS/Gaps in Care may include immunizations, cancer screenings, flu shots, etc. The ECM LCM will need to educate the member on the importance of preventative care,

discuss details of missing HEDIS/ Gaps in Care measure, and assist member with care coordination to help remove potential barriers.

- The Member Activity Report is outbounded daily and contains all the members who are enrolled and assigned to each ECM Provider. The Member Activity Report includes information such as member demographics, Populations of Focus, active Community Support authorizations and effective/term dates, and the assigned CS Provider(s). This report can serve as resource for ECM Provider oversight and monitoring.

Access to CCA

Molina's ECM Team offers access to CCA to all ECM Providers. ECM Providers may benefit from requesting CCA access for their ECM staff. Your ECM staff can review member information that might assist with outreach, the pre-call review exercise, development of the care plan, historical member data, clinical notes, etc. If your organization is interested in this resource, please reach out to Molina's ECM Team request access and inquire about training.

Members Aging Out

Youth members approaching the age of 21 need to be assessed by their assigned ECM LCM to determine which Adult Population(s) of Focus the member meets. The ECM LCM is highly encouraged to set reminders 60 days prior to the member turning 21. The ECM LCM might determine that the member does not meet any Adult Population of Focus criteria, however, they still have care coordination needs under Child/Youth Population(s) of Focus. If this is the case, the member will continue receiving ECM services and should not be disenrolled from ECM, instead, the ECM LCM needs to apply the "graduation" criteria to determine when the member is ready to disenroll.

The ECM LCM must:

- Discuss the Adult Populations of Focus criteria with the member.
- Document the discussion and date of discussion in their EHR.
- Note the Adult Population(s) of Focus the member qualifies or if they don't qualify what Child/Youth Population(s) of Focus they continue to qualify.
- Provide these PoF updates to Molina's ECM Team via the monthly RTF.

For more information on these requirements, refer to the OTF/RTF Training in the **Attachments** section. The new Adult Population(s) of Focus will be updated in the Molina system upon receipt and ingestion of the RTF. To ensure members are reassessed, Molina's ECM Team will send reminders to your organization before the member turns 21 and will ask for the assessment outcome.

Physician Certification Statements

Per APL 22-008, Health Plans are required to obtain a Physician Certification Statements (PCS) form *(found on Molina's public website under **Transportation***: molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx) demonstrating member's need for Non-Emergent Medical Transportation (NEMT).

- The ECM LCM is to reach out to the member's Provider/Facility and request that they complete the authorization request form for NEMT Services.
- The ECM LCM must make up to three (3) attempts to contact the provider/facility.
- Both providers must complete the PCS if the member has multiple standing orders.
- The Provider needs to complete the PCS form and submit the completed form to American Logistics (AL) via fax at (877) 282-8441 or by email at MolinaFax@AmericanLogistics.com.
- The ECM LCM will document this contact in their EHR with the subject line "NEMT PCS outreach" and document the outcome of the contact. The ECM LCM needs to elaborate on any other member findings/discussions held with the provider, as applicable (e.g., "Contacted <Provider/Facility>, educated on PCS form for NEMT mode of transportation for the member's standing order. The provider reported understanding and agreed to complete and submit the PCS form to AL. Provided the members' Provider with the PCS form").
- A PCS Form is also needed for ambulatory door-to-door service transportation; refer to the form for more information.

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

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

BH Crisis Line, Nurse Advise Line, & HEDIS Behavioral Health Encounters

- Molina has a Behavioral Health (BH) Crisis Line that members may access 24/7 year-round. The BH Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals, and/or triage to appropriate support, resources, and emergency response teams. Members experiencing psychological distress may access the BH Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.
- Members may call the Nurse Advise Line (NAL) Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round.
- Molina's ECM Team will notify the ECM Provider if any of their assigned enrolled members have called the BH Crisis Line or had an Emergency Department Visit for Mental Illness and/or Alcohol and other drug abuse or dependence recently or called the NAL and needs follow-up.
- For BH Crisis Line, follow-up needs to be done **by the close of business from the date of notification**.
- For members with Emergency Department Visit for Mental Illness and/or Alcohol and other drug abuse or dependence and for members who called the NAL, follow-up needs to be done within **two business days from** the date of notification.

- These follow-ups need to be documented in the ECM Provider's EHR. Documentation must include:
    - Contact Date
    - Contact Method
    - Contact Direction
    - Respondent
    - Contact Made By
    - Purpose of Contact
    - Outcome of Contact
    - Length of Contact
    - Notes

High-risk Members for Post-suicide Contact

Molina's ECM Team will notify your organization of any assigned high-risk members for post-suicide contact. The goals when contacting these members are to:

- Connect with the member within **48 hours of notification.**
- Ensure the member has a safety plan.
- Get the member connected with appropriate follow-up care.
- When following-up with the member, engage the member and express care and desire to help.
- Reference ED visit(s) and inquire how they have been feeling. Use open-ended questions.
- Assess current risk by asking about current behavioral health treatment, natural supports, and consider administering PHQ9. Implement crisis protocol if needed.
- Offer psychoeducation, linkages to behavioral health services, peer support, warmlines and hotlines.
- Offers CM services.
- ECM LCM and member Agree upon a follow up plan and a safety plan.
- ECM LCM updates the care plan (as needed) and obtains member consent.

If the ECM LCM has not conducted a thorough pre-call review before contacting the member, please conduct one to form a clinical picture. Remember, some behavioral health service details will not be available due to county carve-out.

Letter Templates

ECM LCMs are required to mail state-approved letters to our members and members' PCP (as applicable). The ECM LCM must make every attempt to mail the letter to the member and the member's PCP. The ECM LCM needs to keep in their EHR copies of the ECM letters that were 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 too.

Below is a complete list of Molina's ECM letter templates. ECM Letter templates are located in the **Attachments** section of this manual:

Letter Template	Usage
ECM Generic UTC Letter	To be mailed when a MIF or referred member is unable to be contacted (UTC). The 5th attempt. *Do not mail this letter to a member who is already enrolled in ECM.*
ECM Welcome Letter	To be mailed to newly-enrolled members. If the member meets program requirements and agrees to enroll in ECM, the ECM Welcome Letter is timely sent to the member *within three business days* from ECM Opt-In. *Do not mail this letter to a member who is not enrolled in ECM.*
ECM Care Plan Letter (initial and updates)	To be mailed to an enrolled member upon creating the member's Care Plan and changes to the Care Plan. Mail this letter to the member after creating the care plan (Best Practice: within three business days from completion of the care plan, no later than 90 days from ECM Opt-In) along with a copy of the care plan. For care plan updates, mail this letter and a copy of the care plan to the member. Letter is also available in Spanish in the **Attachments** section. *Do not mail this letter to a member who is not enrolled in ECM.*
ECM PCP Care Plan Letter	To be mailed to the enrolled member's PCP upon creating the member's Care Plan and upon changes to the Care Plan. Mail this letter to the member's PCP after completing the care plan (no later than 90 days from ECM Opt-In) along with a copy of the care plan. For care plan updates, mail this letter and a copy of the care plan. *Do not mail this letter if the member has not been enrolled in ECM.*
ECM Post Opt-In UTC Letter	To be mailed to an enrolled member who is unable to be reached following the UTC process. The 4th attempt. Letter is also available in Spanish in the **Attachments** section. *Do not mail this letter to a member who is not enrolled in ECM.*
ECM Post Opt-In Decline Letter	To be mailed to an enrolled member when the member declines further participation in the program. *Do not mail this letter to a member who is not enrolled in ECM.*
ECM PCP Notification Letter	FYI Only: Molina automatically generates and mails this letter to a newly enrolled member's PCP if the PCP is listed in Molina's system.

If you need any of these letters in another language, please notify Molina's ECM Team: MHC_ECM@MolinaHealthcare.com

Reassessment

Members need to be reassessed at a frequency appropriate for the member's individual progress or changes in needs arise as determined by the member's assigned ECM Provider, and/or as identified in the Care Management Plan.

- Members do not need to be reassessed annually and should instead be reassessed at a clinically appropriate administrative frequency.
- The ECM Program Completion Questionnaire (PCQ) was designed as the "graduation" criteria to determine if the member is ready to graduate from the program or should be downgraded to a lower level of care (e.g., Molina's internal CM Department), or needs to continue with the ECM program (refer to the **Attachments** section for a copy of the latest PCQ template). The PCQ should be administered **before** disenrolling a member if they are ready to graduate from the program or should be downgraded to a lower level of care.
- The ECM LCM should go through the PCQ with the member or member's representative, document the outcome of discussion (refer to the **Care Management Documentation System Requirements** section for full list of documentation requirements), and save the PCQ that was administered in their EHR.

Member and Family Supports

Member and Family Supports include activities that ensure the member and family/support are knowledgeable about the member's conditions, with the overall goal of improving their adherence to treatment and medication management. Member and Family Supports could include, but are not limited to:

- Documenting a member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the member and/or their member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s), as applicable.
- Conducting activities to ensure the member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) are knowledgeable about the member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.
- Ensuring the member's ECM Lead Care Manager serves as the primary point of contact for the member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s)
- Identifying supports needed for the member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) to manage the member's condition and assist them in accessing needed support services and assist them with making informed choices.
- Providing for appropriate education of the Member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) about care instructions for the member.
- Ensuring that the member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) has a copy of his/her care plan and information about how to request updates.

Interdisciplinary Care Team

The interdisciplinary care team's (ICT), also known as the multi-disciplinary team or members, role is to provide input to the development and ongoing maintenance of the member's care plan. The ICT meetings help ensure that the member's care is continuously integrated among all service providers.

Interdisciplinary Care Team Meetings

The ECM LCM is required to coordinate meetings with the member's ICT. ICT participants should include the member's assigned ECM LCM, ECM Director, ECM Clinical Consultant (if ECM LCM is non-clinical), ECM Community Health Workers, and Housing Specialist (as needed). In addition, depending on the member's needs/preferences, the ECM LCM may invite the following individuals:

- ECM Provider Subject Matter Experts, as applicable
- Pharmacist
- Nutritionist
- Caregiver
- PCP/Specialists
- Behavioral Health Providers
- Community Supports Providers
- MedZed HC 2.0 care coordinator (if the member is enrolled in this program)
- My Care Palliative Care (if member enrolled is enrolled in this program)
- Major Organ Transplant (if member enrolled is enrolled in this program)

If a member requested an ICT meeting at any point while enrolled in ECM, an ICT meeting must be held within 30 days of the member requesting it. The ECM LCM should coordinate frequent ICT meetings for all members with high and catastrophic acuity levels based on Molina's Case Management Acuity, members who are homeless and authorized to receive Housing Community Supports, members with recent ED visits or hospitalization (including skilled nursing facility stays), and members with safety concerns, unmet BH/SUD, and/or APS/CPS reports. Nevertheless, all members, even those who have not requested an ICT meeting, the ECM LCM should coordinate ICT meetings at least twice a year.

ICT Meeting Documentation

All ICT Meetings must be documented in the ECM Provider's EHR system. Documentation should include the following:

- Names of all ICT meeting attendees (titles and relationship to member).
- Dates/times ICT meeting occurred and where they were held.
- Notes on the outcome of the ICT meeting. Evidence that ICT meeting recommendations were discussed with the member and incorporated into the care plan as applicable.
- Evidence that meeting details were shared with all ICT members.

ICT Meeting Follow-up

- The member's care plan must be updated based on the ICT meeting recommendations.
- Documentation should evidence of ongoing information sharing among the member's ICT. The updated care plan must be shared with the member, their assigned PCP, and other members of the care team as appropriate, as outlined in the **Comprehensive Assessment and Care Plan** section of this manual.

Clinical Consultant Reviews

Each ECM provider is required to have a Clinical Consultant on their ECM team to oversee the clinical aspects of the program. The Clinical Consultant should review the completed Comprehensive Assessment, additional assessments, care plan, participate in ICT meetings, and provide input during these discussions. Clinical reviews need to take place on a recurring basis (e.g., when ECM LCM is developing the care plan, or updating the care plan due to the member's change in condition or providing input during ICTs, etc.) and must be documented in the ECM Provider's EHR by the Clinical Consultant and should include their full name and credentials. If the ECM LCM holds an appropriate clinical license, additional clinical reviews are not required.

The Clinical Consultant 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 ECM 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.

Grievances

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 act on it as soon as possible, encourage the member to file a grievance, and assist the member in filing the grievance. Refer to the latest Member Handbook on the Molina website for more information on how to file a grievance: molinahealthcare.com/members/ca/en-us/mem/medicaid/medical/memguide.aspx

Once a grievance has been filed, Molina's ECM Team will receive a notification:

- Molina's ECM Team will notify the ECM Provider when a member files a grievance.
- The ECM Provider is required to complete the Grievance Response Form within the given due date to meet state compliance. Even if the grievance is not against the ECM Provider, the ECM Provider is required to review and complete the Grievance Response Form. Depending on the grievance, the ECM LCM might need to contact the member for follow-up or assist with care coordination needs or provide additional information.
- Molina's Appeals & Grievances Team will mail a resolution letter to the member with their assigned ECM LCM's contact information.

ECM Providers are an Extension of Molina Healthcare

We understand that ECM Providers might experience challenges when contacting providers to request member information, such as treatment plans and medication information, to support care coordination needs and comply with our ECM requirements. ECM Providers can reference the Provider Bulletins (formerly Just the Fax) in the **Attachments** section when dealing with providers unaware of the ECM program. These Provider Bulletins help educate providers on CalAIM's Enhanced Care Management Program. As you speak with providers, emphasize that you are an extension of Molina Healthcare. If you experience challenges with Molina's in-network providers, please contact your Provider Services Representative.