
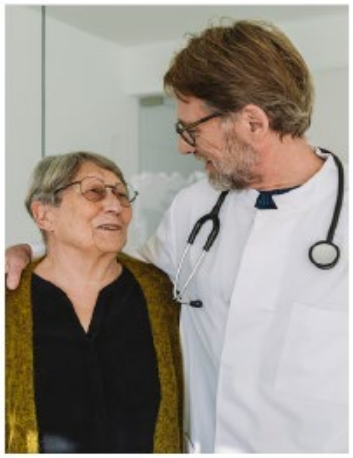


Enhanced Care Management Provider Manual

Part 4

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.

Last Updated: 06/2025

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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Comprehensive Transitional Care

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

Transitional Care Services include, but are not limited to:

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

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

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

Hospital Census Data

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

- Follow up with the member via telephone within **two business days** of discharge (or agreed upon date if contact is made with the member before discharge) to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist. Contact 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 discusses Transition of Care Questions below with the member (and/or parent, caregiver, guardian).
- ECM LCMs are expected to collaborate, communicate, and coordinate with all involved parties.
- The care plan should be updated post-discharge to address hospitalization and measures to prevent readmission.
- The updated care plan should be shared with the member, PCP, and any parties involved in the member's care within 14 days of updating the care plan.
- 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 LCM 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.

Transitions of Care Documentation

All activities involving Transitions of Care are required to be documented in the ECM Provider's EHR system; 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. Documentation should also include the following Transition of Care Questions:

- Admission Date
- Discharge Date
- Discharged from (e.g., inpatient medical, inpatient psych, LTAC/inpatient rehab, skilled nursing facility)
- Discharged to (e.g., assisted living facility, group home, home with self-care, home with home health, residential, other, etc.)
- Admission Diagnosis
- Discharge Diagnosis
- Respondent (e.g., member, caregiver, other, etc.)
- Contact Method
- Ask member or member's representative:
    - What brought you/your child to the hospital?
    - 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?
    - Are you/your child taking any new prescription/OTC medicines prescribed by the doctor?
- Did the dosage of any of your/your child's medications or the frequency with which you/your child take any medications change?
- Are there any medicines that you/your child are no longer taking?
- Have you been able to fill all of your/your child's medication(s)?
- Have you/your child already seen or scheduled an appointment with the doctor/nurse practitioner/therapist indicated in your discharge instructions?
    - Date of appointment
- Have any outpatient services been ordered for you/your child?
- Have you/your child started or scheduled outpatient care?
- What are the symptoms you/your child may experience when having problems and need to get help?
- What will you do if you/your child have new or worsening symptoms?

- Do you/your child need assistance with any of the following?
- Are you having problems with your/your child's care or treatments?
- Were you/your child told to follow a special diet upon discharge?
- Sometimes there are services ordered by the doctor after discharge, for you to be able to better manage your health/care at home. Do you have new order(s) for:
    - Were any home health services ordered for you/your child?
    - Have your home health services already started or been scheduled?
    - Date of scheduled initial home health visit
    - Date of scheduled initial home health visit
    - Was any home equipment/supplies ordered for you/your child?
    - Do you have the equipment/supplies you need?
- Do you have any type of personal health journal like a notebook or an app that contains all of your/your child's health information such as doctors, medications, important contacts, appointments, and health reminders?
- Is there any other concern/issue that you would like to talk about or discuss?

Coordination of and Referral to Community and Social Support Services

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

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

Referrals to Community Support Services

ECM Providers are expected to refer members to Community Support services as applicable. For example, suppose a member is in the "Members Experiencing Homelessness" Population of Focus. In that case, the ECM LCM needs to complete a *Community Supports Housing Services Referral.*

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

Referrals to Social Support Services

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

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

CBAS and In-Home Support Services (IHSS)

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

All Regions		
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)	**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.

	• 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.	Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.
Process	• An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). • If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. • The ICT should collaborate and develop/update the care plan.	• A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. • Based on the need for assistance with ADLs /IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. • If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. • The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process	**Standard referral:** • 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 process:** **Riverside County** • Contact the Department of Public Social Services (DPSS) to initiate an IHSS referral. Web Referral: riversideihss.org/Home/IHSSApply • After a referral is made, download the referral and email it to the LTSS mailbox at CALTSS@molinahealthcare.com, for tracking purposes. **San Bernardino County** • Submit the county IHSS Referral form to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. **Los Angeles County** • Submit Los Angeles County IHSS Referral Form to Molina through the

		Molina CA LTSS mailbox at: CALTSS@molinahealthcare.com. **Sacramento County** • Contact Sacramento County In-Home Support Services directly: • Phone: (916) 874-9471 **San Diego County:** • Contact Aging and Independence Services (AIS) to initiate an IHSS referral: • Phone: (800) 339-4661 • Web Referral: Register and complete referrals **Redeterminations Riverside County & San Bernardino County:** 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. **Los Angeles County Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist the member in contacting IHSS Helpline: (888) 822-9622. **Sacramento Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member to contact Sacramento County IHSS: (916) 874-9471 **San Diego Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member by contacting AIS: (800) 339-4661

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

Discontinuing Delivery of ECM

Circumstances for Discontinuing ECM

Members can decline or end ECM upon initial outreach and engagement, or at any other time. ECM Providers are required to notify Molina to discontinue ECM for members when any of the following circumstances are met via the RTF:

- The member has met all care plan goals.
- The member is ready to transition to a lower level of care.
- The member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a member's behavior or environment is unsafe for the ECM Provider).
- The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts.

If a member has been reported as disenrolled in the RTF, and the member later contacts the ECM Provider wanting to continue with ECM services, a new referral form needs to be submitted to Molina's ECM Team and the member can re-enroll into the program, however, the member will have a new ECM Benefit Start date. Refer to the OTF/RTF Training in the **Attachments** section for more information.

Discontinuation Reasons| Disenrollment

Below is the complete list of discontinuation reasons and descriptions. ECM Providers must indicate in the RTF the discontinuation reason code for members who have been **disenrolled** from the program, along with the ECM Benefit End Date. The ECM Provider's EHR must clearly document a member's disenrollment:

- **Member has met all care plan goals** (discontinuation reason code 1 in RTF) = The member's conditions are well-managed, and care plan goals have been met. No additional problems have been identified; therefore, ECM services are no longer needed, and the member is ready to graduate from the program. The PCQ should be administered prior to disenrolling the member for this reason.
- **The Member is ready to transition to a lower level of care** (discontinuation reason code 2 in RTF) = The member is ready to be downgraded to a lower level of care management. The ECM LCM should complete a direct referral to Molina's CM Department prior to disenrolling the member from ECM and warm hand off the member to the new Lead Care Manager. The PCQ should be administered prior to disenrolling the member for this reason.
- **Member was disenrolled from ECM due no longer wanting to receive ECM services** (discontinuation reason code 3 in RTF) = The member does not want to continue being enrolled in ECM or is unwilling to engage. This can include instances when a

member's behavior or environment is unsafe for the ECM LCM. NOTE: ECM LCM must send the ECM Post Opt-in Decline Letter to the member or member's representative.

- **Unable to contact after exhausting minimum required attempts/Insufficient contact information** (discontinuation reason code 4 in RTF) = The ECM LCM exhausted the minimum required attempts, and the member is unable to be contacted, or the ECM LCM does not have sufficient contact information to get a hold of the member. NOTE: ECM LCM must send the ECM Post Opt-in UTC Letter to the member or member's representative.
- **Member Incarcerated** (discontinuation reason code 5 in RTF) = The member is incarcerated.
- **Member is enrolled in a duplicative program** (discontinuation reason code 7 in RTF) = If at any point while the member is enrolled in ECM the ECM LCM identifies that the member is receiving duplicative services from another DHCS-approved program, the member might need to be disenrolled from the ECM program. In some cases, the member may choose to continue in the ECM Program, and in some cases, they cannot continue 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, do not disenroll the member, notify Molina's ECM Team and the member will be reassigned to an ECM Provider who contracts in the member's county and the member will continue to receive ECM services. A warm handoff is needed in this circumstance.
- **Member moved out of the country** (discontinuation reason code 11 in RTF) = The member no longer resides in the country. Also, if the ECM LCM was 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 they are informed that the member is out of the state/country and don't know the member's return date, the ECM LCM should 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.
- **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 LCM. NOTE: Some of our members are very complex and might benefit from being reassigned to another ECM LCM or another ECM Provider. Consider these options

before disenrolling a member. Molina's ECM Team is here to support during these circumstances, feel-free to reach out.

- **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) = If at any point while the member is enrolled in the program, the ECM LCM identifies that the member does not qualify for at least one Population of Focus (e.g., member erroneously referred into the ECM Program), the member needs to be disenrolled.

Members' disenrollment can be voluntary or involuntary. If the ECM LCM is disenrolling the member involuntarily, attempts must be made to notify the member, documented via the ECM Provider's her system, 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 their EHR system.

We defer to our ECM Providers to apply their own judgment to determine if a member should continue with ECM or should be downgraded to a lower level of care (Molina's CM Department) or graduated completely from the ECM program. The ECM LCM can determine this through monitoring the member's care plan goals and the completion of the PCQ, which should be administered at a frequency that is appropriate for the member's individual progress or changes in needs. 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 specialists?
- Does the member have stable housing?

Closing the Member's Care Plan

Prior to disenrolling a member from the ECM program, the ECM LCM must update the care plan to indicate reason for closing the care plan and its milestones. In addition, the ECM LCM should close any items that are opened for the member in the ECM Provider's EHR.