Molina Healthcare of California

Member Care Management Referral Guide

Molina’s Community Health Worker Benefit, Case Management Program and the Enhanced Care Management Program

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MolinaHealthcare.com

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Contents

Member Transitions and Referral Process Provider Guide Purpose

The purpose of this document is to outline the member transition scenarios involving Molina's population Health Management (PHM) team, Care Management (CM) team, Enhanced Care Management (ECM) team, and Molina's external Community Health Worker (CHW) Supervising Providers, and ECM Providers.

This guide offers an overview of the programs Molina Healthcare provides to support members with their health needs. It also outlines the criteria for each program to help providers refer their patients to the program that best aligns with the level of care that would benefit them most.

Program Overview and Criteria

Community Health Worker Benefit

CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health (Title 42 Code of Federal Regulations (CFR) Section 440.130(c)).

Requirements and guidelines for the CHW benefit are established by the Department of Health Care Services (DHCS) in All Plan Letter (APL)24-016: CHW Services Benefit and the Medi-Cal Provider Manual.

Members are eligible for CHW Services at all levels of care although the Member will be offered the highest level of care they are eligible for. Members enrolled in Enhanced Care Management (ECM) cannot also receive CHW services outside of their ECM Core Team. Members must meet eligibility criteria outlined in the DHCS APL 24-016: Community Health Worker Services Benefit, the Medi-Cal Provider Manual section titled CHW Preventive Services, or any superseding guidance. CHW Services are preventive and do not require a prior authorization.

CHWs are trusted members of their community who help address the issues that are affecting the physical and mental health of their community members. CHWs are not licensed clinicians. CHWs may include individuals such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

A CHW may:

- Assist a member with finding an appointment to treat a behavioral health condition.
- Provide a member with health education to control a chronic condition.
- Provide a member with resources to prevent infections.
- Assist a member with accessing services for their sexual or reproductive health.
- Educate a member on the importance of prenatal and postpartum health care.
- Encourage a member to attend preventive appointments, including cancer screenings and immunizations.
- Refer a member to domestic or intimate partner violence support services.
- Support a parent or guardian without Medi-Cal coverage on behalf of a child under age 21 on Medi-Cal, if the child is present.

Care Management

Case Management Program

Molina's Case Management Program is a comprehensive integrated Medical/Social Case Management Model designed to focus on promoting the coordination of social support and medical services across the entire continuum of care. Our program is a collaborative process of providing services where a professional team of Nurses, Social Workers, and other disciplines work with the member's healthcare providers to assess the individual healthcare needs of the member and the member's family, when appropriate. The ultimate goal is to improve the overall quality of care.

Case Management services include but are not limited to:

- Chronic Disease Management (any member with a chronic condition)
- Coordination of Care for Autism
- Coordination of Benefits
- Behavioral Health Needs
- Behavioral Health Care Coordination
- General Care Coordination Needs

Molina Healthcare staff can help a member:

- Access services that they are eligible to receive
- Coordinate appointments and tests
- Coordinate transportation
- Identify any gaps in care or health care needs
- Access resources to help individuals with special health care needs and/or their caregivers deal with day-to-day stress
- Coordinate moving from one setting to another. This can include being discharged from the hospital
- Assessing eligibility for long-term care services and supports
- Connect with community resources
- Find services that might not be benefits. This includes community and social services programs such as physical therapy with the schools or "Meals on Wheels"
- Coordinate services with a primary care physician (PCP), family members, caregivers, representatives and any other identified provider

Medi-Cal: The Molina Case Management team is available Monday- Friday from 8:30am-5:30pm.

Case Management team can be reached by phone at 833-234-1258, by fax at 562-499-6105, or by email at MHCCaseManagement@MolinaHealthcare.com.

Enhanced Care Management

What is Enhanced Care Management?

Enhanced Care Management (ECM) is a Medi-Cal benefit available to qualifying members as part of the DHCS CalAIM initiative. Starting January 1, 2022, Medi-Cal plans offered Enhanced Care Management (ECM). ECM is defined as comprehensive, whole-person care management that will be available to high-need, high-cost Medi-Cal Managed Care enrollees with the goals of better-coordinating care, addressing social determinants of health, and improving health outcomes.

The goal of ECM is to address the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management. The benefit is community based, interdisciplinary, high touch and person centered.

ECM helps coordinate:

- Primary care
- Acute care
- Behavioral health
- Community-based long-term services and supports (LTSS)
- Intellectual or developmental disability (I/DD)
- Oral health

ECM offers Molina members their own care team, including a Lead Care Manager (LCM). The LCM will work with members and their doctors, specialists, pharmacists, case managers, social services providers and others to ensure everyone works together to help members get the care they need. The LCM can also help members find and apply for other services in their community.

ECM services include:

- Outreach and engagement
- Comprehensive assessment and care management plan
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family supports
- Coordination of and referral to community and social support services

Who is eligible for Enhanced Care Management services?

To be eligible for ECM, Members must be enrolled in Medi-Cal Managed Care and meet the criteria established by DHCS for each of the ECM Populations of Focus (PoF) per the DHCS ECM Policy Guide.

The PoFs are as follows:

ECM is designed to assist the following populations of focus:

- Adults experiencing homelessness (single)
- 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

How to access Enhanced Care Management services

Medical and social service providers are encouraged to discuss this benefit with members. To be eligible for ECM, members must meet at least one of the populations of focus outlined in the ECM Member Referral Form. Providers can submit a referral to ECM using the ECM Member Referral Form located in the Appendix section of this guide. Please visit our website to understand the process of reviewing requests for ECM services. Below are some additional helpful resources:

- Visit the DHCS website for:
    - For more information on ECM
    - The ECM member toolkit
- Molina's Provider Online Directory

Member Transition and Referral Processes

The below table provides member transition scenarios that provide guidance on the referral process providers should follow when referring a member to a program that best suits their individualized needs.

Transition Scenario 1:

Member has been identified as needing Community Health Worker services.

CHW services include:

- Health Education
- Health Navigation
- Individual Advocacy and Support
- Completion of Screeners and Assessments

Follow the transition referral process that applies to the member current status:

Community Health Worker Benefit	Case Management	Enhanced Care Management
If the member has identified a CHW Supervising Provider they would like to be assigned to, refer the member directly to the requested CHW Supervising Provider. If the member has not identified a specific CHW Supervising Provider, please complete the CHW Referral Form, found on the Molina Provider website under "Frequently Used Forms." Once completed: • Call 844-926-6590 to submit referral telephonically **OR** • Email referral to CA_SDOH_Connectors@MolinaHealthcare.com	If the member has an assigned Molina Case Manager, please refer the member to their CM for follow-up.	If the member is already enrolled in Molina's Enhanced Care Management Program, they are ineligible to receive the CHW Benefit. Member should work with their Lead Care Manager on their ECM team or explore other State supported resources. If a member has graduated or disenrolled from ECM and agrees to a referral to the CHW Program, the ECM Provider will complete the ECM Disenrollment form in CCA or submit the disenrollment information via file exchange for the graduation. The ECM Provider will complete the CHW Referral Form, found on the Molina Provider website under "Frequently Used Forms." Once completed: • Call 844-926-6590 to submit referral telephonically **OR** • Email referral to CA_SDOH_Connectors@MolinaHealthcare.com

Transition Scenario 2:

Member has been identified for Case Management services.

Case Management services are ideal for members who require a mid-level of care. Reasons a member may require a mid-level of care that exceeds the scope of what a CHW can provide may include:

- Chronic Disease Management (any member with a chronic condition)
- Coordination of Care for Autism
- Coordination of Benefits
- Behavioral Health Needs
- Behavioral Health Care Coordination
- General Care Coordination Needs

Follow the transition referral process that applies to the member current status:

Community Health Worker Benefit	Case Management	Enhanced Care Management
If the member has an assigned CHW Supervising Provider that has determined the member is in need of Case Management, the CHW Supervising Provider will complete the Case Management Referral Form found on the Molina Provider website under "Frequently Used Forms." Once completed, email referral to MHCCaseManagement@MolinaHealthcare.com	If the member is already receiving Case Management services and a new need has been identified, refer them to their assigned CM.	If a member has graduated from ECM and agrees to a referral for Care Management services, the ECM Provider will complete the ECM Disenrollment form in CCA or submit the disenrollment information via file exchange for the graduation. The ECM Provider will complete the Case Management Referral Form found on the Molina Provider website under "Frequently Used Forms." Once completed, email referral to MHCCaseManagement@MolinaHealthcare.com

Transition Scenario 3:

Member has a newly identified need that meets the criteria for one of ECM's Populations of Focus (PoFs).

ECM is designed to assist the following populations of focus:

- Adults experiencing homelessness (single)
- 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

Follow the transition referral process that applies to the member current status:

Community Health Worker Benefit	Case Management	Enhanced Care Management
If the CHW Supervising Provider that the member is currently working with is **a Molina contracted ECM Provider**, the CHW Supervising Provider can terminate the CHW Benefit with the member in favor of starting the ECM relationship with the member. This is done by sending in an ECM Referral Form, found on the Molina Provider website under "Frequently Used Forms." Once completed, email referral to MHC_ECMReferrals@MolinaHealthcare.com. If the CHW Supervising Provider that the member is currently working with is **not a Molina contracted ECM Provider**, the CHW Supervising Provider can send in an ECM Referral Form, found on the Molina Provider website under "Frequently Used Forms." Once confirmed that Member has connected with the ECM Provider, the CHW benefit relationship must discontinue. Once completed, email referral to MHC_ECMReferrals@MolinaHealthcare.com.	If the member is already receiving Case Management services and a new need has been identified, refer them to their assigned CM for confirmation that they meet ECM's Population of Focus criteria.	If the member is already enrolled in Molina's Enhanced Case Management Program and has had additional needs identified, refer them to their ECM Care team for support and resources. A member would only be referred for ECM if their newly identified need means they now meet one of the ECM Populations of Focus criteria.

Transition Scenario 4:

None of the transition examples apply and you have further questions.

If none of the transition scenarios apply or you have additional questions, please contact your assigned **Provider Relations Representative** who will ensure the appropriate team reaches out to you for follow-up.

Molina Healthcare Contact List

Molina Healthcare of California

Molina's normal business hours are 7:30 AM – 5:30 PM, Monday to Friday.

Provider Relations	Main Phone	Member Services Toll Free *Available 24/7*
Molina Healthcare of California (MHC) – Provider Relations Representatives	562-499-6191 TTY: 711	888-665-4621 TTY: 711

Community Health Worker Program

Population Health Management	Contact Number	Email Address
Aita Romain, Director – Adult Population Health	562-549-4786	Aita.Romain@MolinaHealthcare.com
Ying Marilyn Kempster, Manager – CHW Program Supervisor	562-549-4634	Ying.Kempster@MolinaHealthcare.com
Social Determinants of Health Community Connectors	844-926-6590	CA_SDOH_Connectors@MolinaHealthcare.com

Case Management

Case Management	Contact Number	Email Address	Line of Business
Blanca Martinez, Director – Healthcare Services	562-485-4966	Blanca.Martinez@MolinaHealthcare.com	Medi-Cal- Adults
Janelyn Martin, Director – Healthcare Services	562-549-4899	Janelyn.Martin@MolinaHealthcare.com	Medi-Cal-Adults
Case Management Referral Line	833-234-1258	MHCCaseManagement@MolinaHealthcare.com	Medi-Cal-Adults
Case Management (Medi-Cal – Peds) (IE (RIV & SB) County)		IEPedsCM@MolinaHealthcare.com	Medi-Cal -Peds
Case Management (Medi-Cal – Peds) (LA County)		LAPedsCM@MolinaHealthcare.com	Medi-Cal -Peds
Case Management (Medi-Cal – Peds) (SAC County)		SacPedsCM@MolinaHealthcare.com	Medi-Cal -Peds
Case Management (Medi-Cal – Peds) (SD County)		SDPedsCM@MolinaHealthcare.com	Medi-Cal -Peds
Case Management	888-858-2150	CM_MP_West@MolinaHealthcare.com	Marketplace
Case Management		Medicare_CM_Team@MolinaHealthcare.com	Medicare EAE D-SNP

Enhanced Care Management

Enhanced Care Management	Contact Number	Email Address
Asya Anderson, Director – Healthcare Services	562-456-4038	Asya.Anderson@MolinaHealthcare.com
Deborah Bowyer, Manager – Healthcare Services		Deborah.Bowyer@MolinaHealthcare.com
Enhanced Care Management		MHC_ECMReferrals@MolinaHealthcare.com

Appendix

Helpful Links and Resources

Program Overview	
Community Health Worker Benefit	Community Health Worker Program
Case Management (Medicaid & Marketplace)	Care Management
Enhanced Care Management	ECM Provider Manual

Referral Forms	
All Frequently Used Forms	Frequently Used Forms
Community Health Worker Benefit	Community Health Worker Referral Form Molina Healthcare of California
Case Management (Medicaid & Marketplace)	Case Management Referral Form
Case Management (Medicare)	Case Management Referral Form
Enhanced Care Management (Adult)	Enhanced Care Management (ECM) Adult Member Referral Form
Enhanced Care Management (Child & Youth)	Enhanced Care Management (ECM) Child and Youth Member Referral Form