ECM AUDIT TRAINING

March 2026

MOLINA® HEALTHCARE

General Information

Please make sure to remain on mute unless you have a question.

Feel free to ask any questions as we go through each audit element.

We will provide a copy of this PowerPoint along with recap of notes after the training.

Please reach out with any questions.

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Why do internal audits?

These internal audits are designed to highlight improvement areas and ensure readiness for state audits, helping prevent the need for a Corrective Action Plan (CAP).

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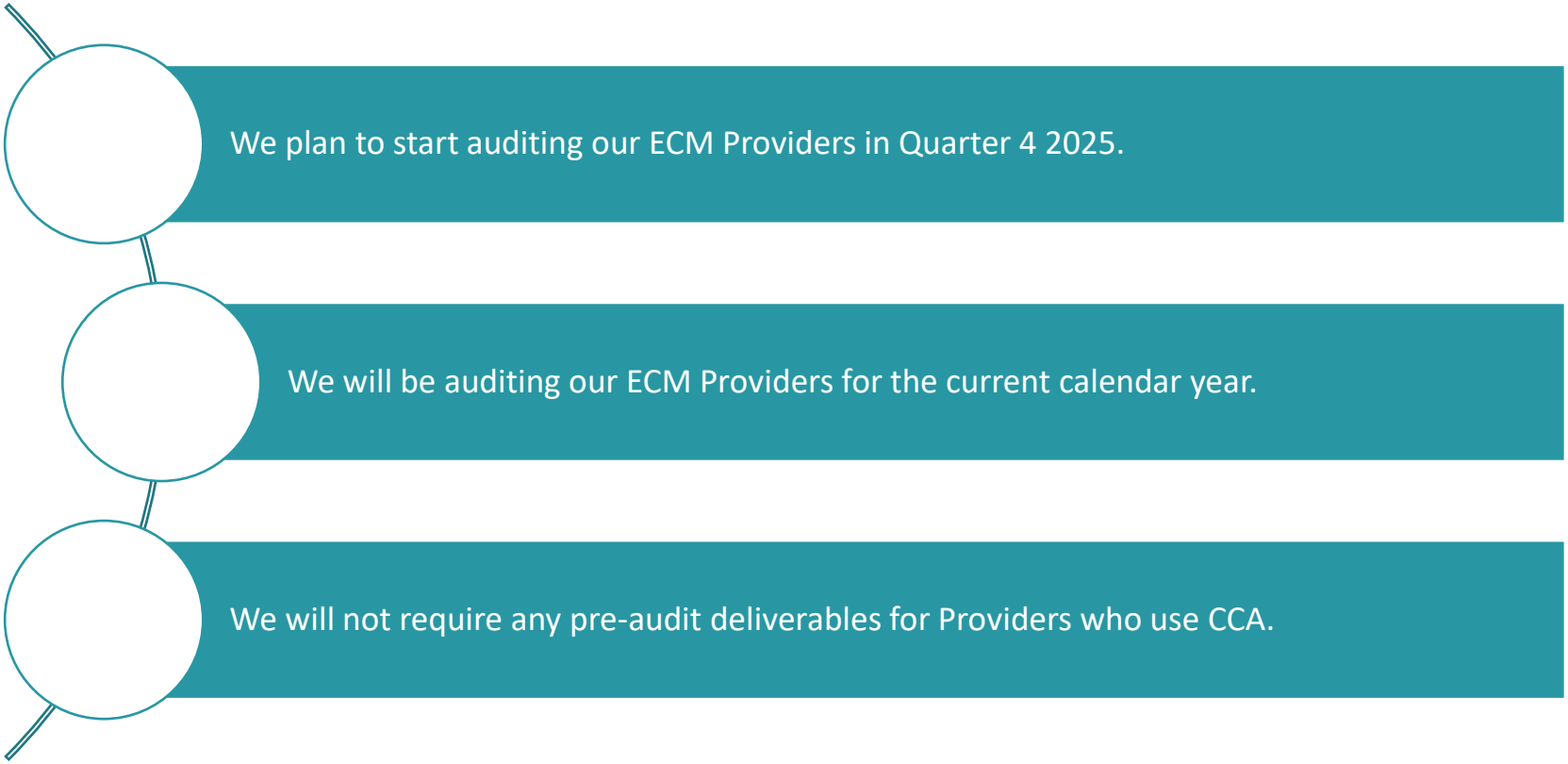
When?


We plan to start auditing our ECM Providers in Quarter 4 2025.
We will be auditing our ECM Providers for the current calendar year.
We will not require any pre-audit deliverables for Providers who use CCA.

ECM Audit Guide Training *(CCA Users)*

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1. **If the provider decides to accept the referral or MIF member, Provider initial outreach member attempt is within 5 business days from receipt of the MIF or date of referral. A member should not have a Pending or Accepted status more than once via CLR form in CCA if you have already reported one of these status previously.**

Initial outreach was attempted within 5 business days from the MIF or date of referral. The CLR form can only be in pending or accepted status once.

If the initial outreach is done past the 5 business days from MIF or date of referral it will be marked as not met. The CLR form is pending or accepted status more than once.

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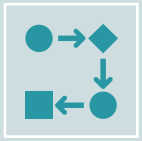
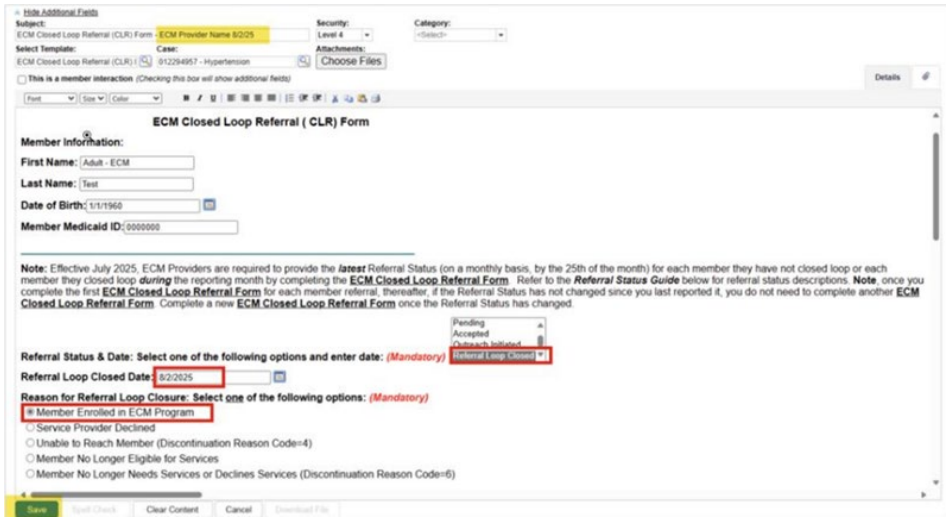
2. **Complete a total of 5 outreach attempts (4 non-mail attempts and 1 mailed attempt) within 90 calendar days from the receipt of the MIF or date of referral. Attempts are different days and times using at least 3 different modalities (in person, phone, email), a member should not have an Outreach initiated status via CLR form for no more than (90) calendar days.**

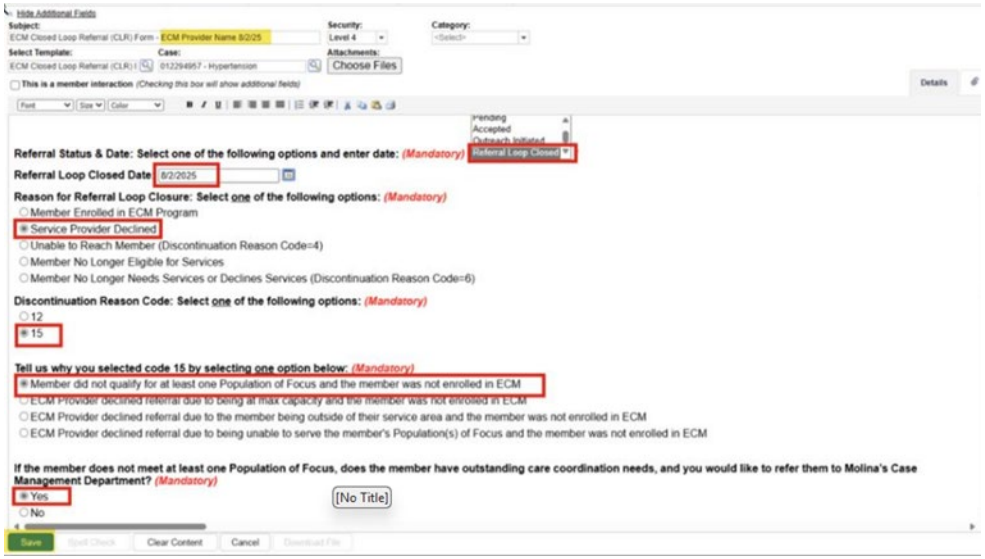
There needs to be a total of 5 outreach attempts done within 90 calendar days from the receipt of the MIF or referral.

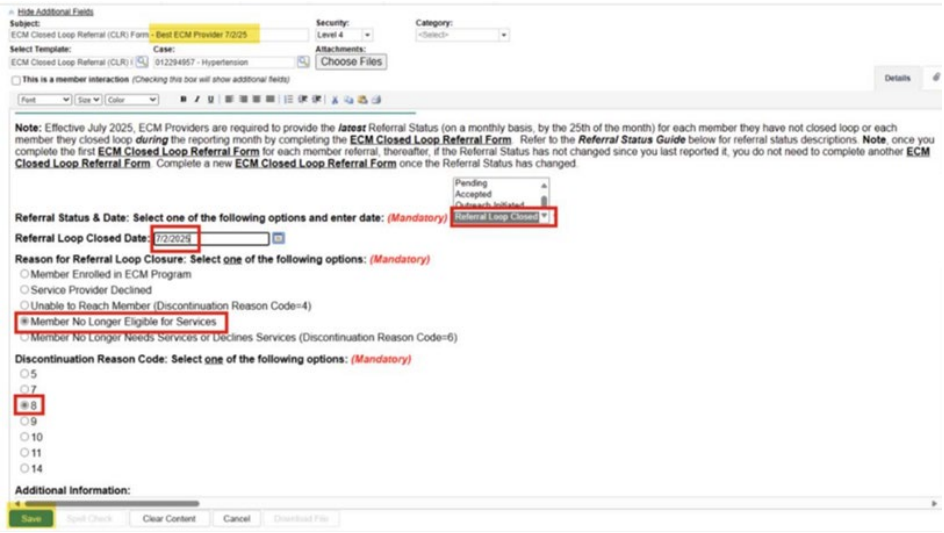


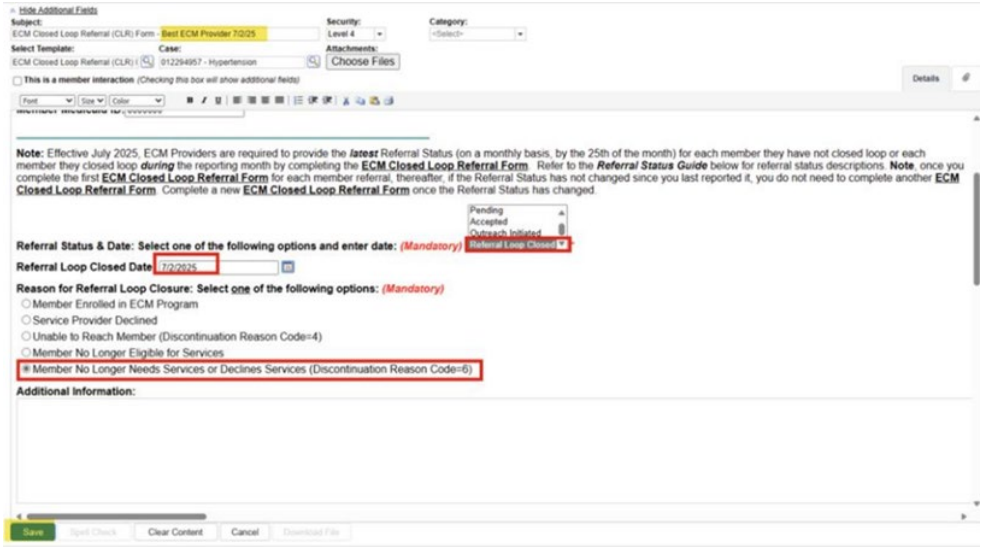
Outreaches need to be done on different days at different times.

If the outreaches are not done within 90 calendar days from the receipt of MIF or referral or if the outreaches are not done on different days and times, it will be marked as not met.









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3. **If you are unable to contact (UTC) the member at any point prior to or after enrollment, documentation of research for additional contact information (review of available notes, auth notes, admission/discharge notes, call to PCP and pharmacy, referral to Member Location Unit (MLU)), appropriate outcome documented.**

When the member becomes UTC the ECM staff is to research for additional contact information. This is to be documented within the progress note

If there is no documentation to support that there researched for additional contact information for the member it will be marked as not met.

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4. **If member was successfully contacted, ECM program eligibility and Populations of Focus were reviewed and member consented into ECM, ECM Provider to complete an Enrollment Assessment.**

Need to ensure the ECM Enrollment Assessment is completed with the eligibility section completed.

If the ECM Enrollment Assessment is not completed or the eligibility section is left blank will be marked as not met.

5. If member meets program requirements and agrees to enroll in ECM, the ECM Welcome Letter is sent to the member timely (within 3 business days).

The welcome letter need to be sent within 3 business days of being enrolled into the ECM program.

If the ECM staff is unable to send out letter due to the member being homeless, then there should be documentation within a progress note to indicate why letters were unable to be sent.

If the welcome letter is sent past 3 business days of being enrolled into the ECM program, or if there is no documentation as to why the letter was not sent to the member, and CLR form has not been completed, it will be marked as not met.

6. The ECM care manager ensures that both the member and their family are actively engaged in supportive activities and well-informed about the member's conditions.

ECM LCM is required to provide a copy of the completed care plan to the member and/or their representative and the member’s PCP after creating the care plan.

If care plan was not shared with member and/or their representative and PCP, this element will be unmet.

7. Document member's preference in regard to engagement.

Document member’s preference in the contact form and in Member Enrollment into ECM.

Provide member’s contact method; Phone number, Best place for Face to Face, updated mailing address, and if member prefers texting.

If there is no documentation of member’s preference in contact form will make this element unmet.

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8. **ECM Care Manager assigns themselves as the Lead Care Manager and updates the Address Book with their contact information (within 5 business days of enrolling a member).**

The ECM Lead needs to be assigned to the member, and this is seen within the assignment list in CCA.

The ECM Lead is to add their information within the members address book as a contact for the member.

If this is not done within 5 business days of enrollment into ECM program, it will be marked as not met.

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9. LCM conducts and documents a pre-call review for enrolled members at least once a month prior to member outreach (review of CCA member dashboard information, available clinical notes, HEDIS Care Gaps, Availity).

Pre-call review is to be documented within the contact form in the notes section and addressed in care plan as appropriate section. Pre-call review are to be done post-enrollment. ECM Providers to complete one (1) pre-call review each month.

The ECM Lead is to review systems and document in the pre-call review as to ensure they discuss these findings with the member.

If there is no detailed documentation that the ECM lead reviewed systems or if there is no documentation as to why it was not reviewed with the member, it will be marked as not met.

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10. ECM Lead Care Manager documents their credentials and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate and person-centered manner (within 5 business days from assigning an ECM LCM to the member).

The ECM Lead Care Manager (LCM) is to document their credentials and confirmation of their expertise and skills within the notes section of the contact form.

The documentation needs to be done within 5 business days from assigning to an ECM Lead Care Manager (LCM) to the member.

If this is not done within 5 business days of assigning an ECM Lead Care Manager (LCM) it will be marked as not met.

For example:

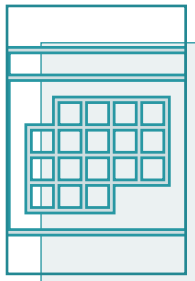
> I, [redacted] RN, am the assigned ECM LCM to this member. I confirm my expertise and skills to serve this member in a culturally relevant, linguistically appropriate, and person-centered manner.

11. ECM Lead Care Manager ECM Lead Care Manager (LCM) provided timely and accurate Close Loop Referral Status updates via CLR form in CCA and documents the reason for Close Loop Referral (effective 7/1/25 - for members who have not closed loop by 7/1/25).

Member must meet the below criteria for reasons to Close Loop on a Referral:

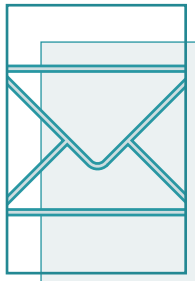
1. Member Enrolled into ECM
2. Service Provider Declined
3. Unable to Reach Member
4. Member No Longer Eligible for Services (Member is deceased, Incarcerated, Duplicative program, Lost Medi-Cal coverage, Switched health plans, Moved out of country, Moved out of county, Member does not qualify for at least one Population of Focus)
5. Member No Longer Needs Services or Declines Services

12. Timely completion of the Comprehensive Assessment (within 60 days of the member's opt-in date) is documented in a contact form with correct purpose of contact/outcomes, clear notes and length of contact. ECM Providers are required to document all attempts made toward the completion of the Comprehensive Assessment (whether they were successful or not) via a Contact Form in CCA.

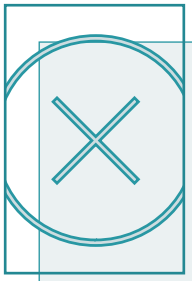


Comprehensive Assessments needs to be completed within 60 days of the member's opt in date.

Contact form is filled out correctly as outlined within the provider manual.



UTC process is to be followed which is 3 attempts and 1 letter.



If this is not followed, then it will be marked as not met.

13. All sections are complete or if a section is not applicable, the reason is indicated. Main Health Concern is targeted and narrowed down to 1 or 2 health conditions.

Assessment is to be filled out completely.

If there are any blank sections within the Assessment, then there needs to be documentation as to why it was left blank.

If there is no documentation to support why it was left blank, then it will be marked as not met.

14. Documentation of member's health status assessment, including medical conditions, member self-assessment and other applicable assessments based on responses to Comprehensive Assessment (i.e., trauma assessment). Please note, the condition specific assessments are not required.

There must be documentation of the member's health status based on responses to Comprehensive Assessment in CCA

If completing additional condition-specific assessments or other tools, the ECM LCM should incorporate findings from all available assessments when completing the Care Plan.

If there is no documentation of the members health status based on responses to Comprehensive Assessment, then it will be marked as not met.

15. If member is in the “Members Experiencing Homelessness” population of focus, there is documentation of member referral to CS Housing services.

Within the ECM Comprehensive assessment if the member is experiencing homelessness, we should see documentation of this.

ECM Lead Care Manager needs to have documentation within the contact form that the member was referred to CS Housing services.

If the member is experiencing homelessness and it is not documented that they were referred to CS Housing services, it will be marked as not met.

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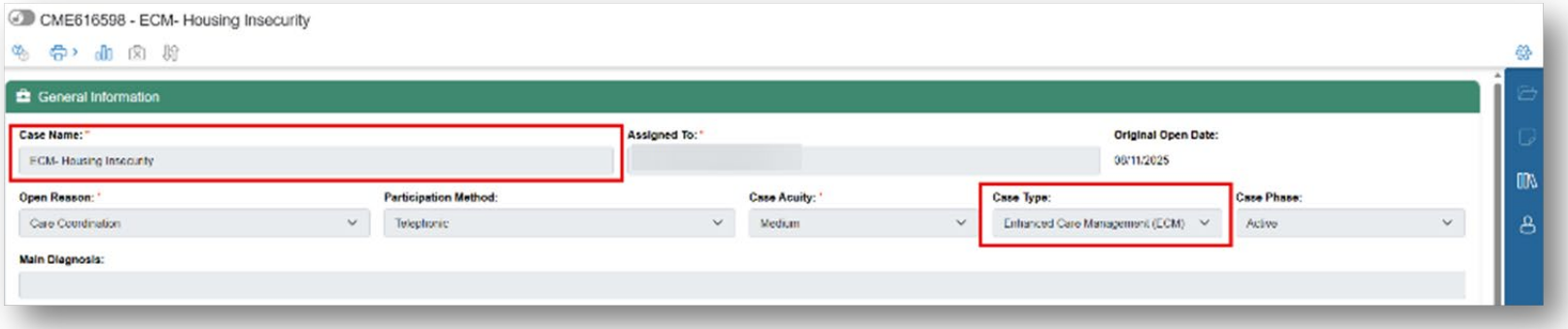
16. **The ICP is created for the ECM enrolled member based on the Comprehensive Assessment. ICP should have ECM in subject line and Enhanced Care Management for Case Type.**



17. The ICP is completed within 90 days from the date the member opts in (best practice within 2 days of completion of the comprehensive assessment).

ICP to be completed within 90 days from the member opt in date.

If the ICP is completed past 90 days from the member opt in date it, will be marked as not met.

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18. ICP is member-centric, documents the member's main health concerns, including all which could include the members identified needs (i.e., LTSS, BH, Community Based Services and Housing Navigation), care gaps, and self-management goals based on Comprehensive Assessment .

Within the ICP the members main health concern, identified needs, care gaps, and self-management conditions/concerns need to have their own PGIO.

If none are part of the ICP, there needs to be documentation to explain why it is not part of the ICP.

If the main health concern, identified needs, care gaps, and self-management conditions/concerns are not part of the ICP and do not have documentation as to why, it will be marked as not met.

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19. If member refuses to work on an identified need, this is documented within the contact note.

If the member does not want to work on identified needs, ensure that it is documented within the contact form.

This documentation is to support the reason why identified need is not part of the ICP.

This is to close the loop. If there is no documentation to support the reason why identified need(s) is not part of the ICP it will be marked as not met.

20. The ICP is prioritized and contains a mix of long-term and short-term goals.

The PGIOs need to prioritized.

If this is a new ICP, then it needs to contain a long-term and short-term goal.

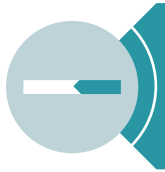
If one or both are missing, then it will be marked as not met.

Must have at least one member prioritized long-term goal (>60 days) and at least one member prioritized short-term goal (≤60 days).

21. All anticipated goals are in SMART format (Specific, Measurable, Achievable, Relevant, and Time-bound). Outcomes are realistic and are individualized to the member.

All goals are to be in SMART format.

Outcomes are to be realistic and member specific.



If one or both are missing, then it will be marked as not met.

Specific	The goal is detailed and exact.
Measurable	The goal has criteria to measure progress and determine if the member is on track to reach their goal.
Attainable	The goal must be well achievable and within reach
Relevant	The goal must be important to the member
Time-Bound	The goal must have a start and finish date.

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22. The care plan includes member-centric barriers.

Any barriers that were identified within the comprehensive assessment or in discussion with the member, needs to be included in the ICP.

If a barrier is not added to the ICP, then there needs to be documentation to support why it was not included in the ICP.

If a barrier is not part of the ICP and there is not documentation to support why it is not in the ICP, it will be marked as not met.

23. ICP does not contain any overdue milestones.

Make sure that the ICP does not have any past due milestones.

It would be seen with the due date(s) being red.

If there are past due milestones, then it will be marked as not met.

24. The ICP was updated at a frequency appropriate for the member's individual progress or changes in needs

If the member has significant changes the expectation is that they are reassessing the member to help manage their conditions/concerns.

The ICP needs to be updated to reflect these changes/updates.

If the ICP is not updated with the members significant change or health status it will be marked as not met.

25. Acuity is appropriate based on members needs and conditions and documented in CCA/care plan reporting template.

ICP acuity level is appropriate.

If the acuity level is not correct, then it will be marked as not met.

Medium Acuity	High Acuity	Catastrophic Acuity
• Maternity High Risk • Three or four co-morbid conditions • Targeted diagnosis with two admits within six months - CVD - CHF - COPD - ESRD - Asthma - Diabetes - Sickle Cell - AIDS/HIV - Cancer - Behavioral Health (specific codes) • Three to five avoidable Emergency Department visits within six months	• Five or more co-morbid conditions • Reports health as poor • High-risk chronic illness with clinical instability as demonstrated by three or four admits within six months related to: - CVD - CHF - COPD - ESRD - Asthma - Diabetes - Sickle Cell - AIDS/HIV - Cancer - Behavioral Health (specific codes) • Six or more avoidable Emergency Department visits within six months	• High-risk chronic illness with clinical instability as demonstrated by five or more admits in six months related to: - CVD - CHF - COPD - ESRD - Asthma - Diabetes - Sickle Cell - AIDS/HIV - Cancer - Behavioral Health (specific codes) • Imminent risk of: - Inpatient admissions (psychiatric or medical) related to inability to self-manage in current living environment - Institutionalization • Need assistance with four or more activities of daily living, independent activities of daily living and lacks adequate care giver assistance.

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26. Proof of documentation via a contact form of the Clinical Consultant name, credentials that they reviewed and provided input to the Comprehensive Assessment and/or ICP. If the Lead Care Manager holds an appropriate clinical license, no clinical consultant review is required.

IF THE ICP IS UPDATED BY CLINICAL CONSULTANT DOCUMENTATION IS TO BE DONE WITHIN THE CONTACT FORM PROVIDING SUMMARIZATION OF THE ICP UPDATE AND WHY.

THE DOCUMENTATION NEEDS TO INCLUDE CLINICAL CONSULTANT CREDENTIALS (REFER TO EXAMPLE IN THE BOX).

> On 4/10/24, I presented the care plan to our clinical consultant, Nadine Khan, RN. Nadine reviewed the care plan and had no additional feedback to provide. I will meet again with Nadine to discuss the member's progress next month.

IF THERE IS NO DOCUMENTATION WITHIN CONTACT FORM AND NO CREDENTIALS, THEN IT WILL BE MARKED AS NOT MET.

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27. The ICP was shared with the Member within 90 days from the member's opt in date (best practice within 3 business days from completion of the ICP). Documentation that letter was mailed.

The member care plan letter should be sent to the member within 90 days from the member's opt in date.

Best practice is to send it within 3 business days from completion of the ICP.

If the care plan letter is not sent within 90 days of the member's opt in date, then it will be marked as not met.

29. The ICP was shared with the PCP within 90 days from the member's opt in date (best practice within 3 business days from completion of the ICP). Document a letter was mailed.

The PCP care plan letter should be sent to the member within 90 days from the member's opt in date.

Best practice is to send it within 3 business days from completion of the ICP.

If the care plan letter is not sent within 90 days of the member's opt in date to the PCP, then it will be marked as not met.

29. Documentation reflects development and member consent of a schedule to timely follow-up/communication with the member to monitor progress and compliance with case management plans and goals and is modified based on the member's identified.

Documentation is to be seen within the contact form/progress note of a scheduled follow-up/ communication agreed with the member.

Documentation to reflect the members process and if any identified changes/updates as well.

If one or both are not seen, then it will be marked as not met.

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30. Documentation of on-going care management of the member's needs is documented in a contact form with correct purpose of contact/outcomes, clear notes and length of contact. (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.).

Contact form is to be filled out correctly as outlined within the provider manual.

Documentation is to show in detail of the on-going care management of the member's needs.

If the contact form is not filled out correctly and documentation does not reflect on going care management of the member's needs, it will be marked as not met.

31. Appropriate referrals are made and documentation of follow up of referrals (i.e., to community supports, CBAS, IHSS) if applicable, to ensure needs are met and care gaps are closed.

ECM team are to refer members to community supports, CBAS, IHSS etc., and provide them the resources they need.

Appropriate referrals are to be documented in a CCA progress notes. Documentation needs to reflect how the resources were provided to the member and how follow ups are being done to ensure needs are being supported.

If there is no documentation to support that these resources were provided to the member, it will be marked as not met.

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32. 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. (If requested by the member)

If ICT was not held within 30 days or members request, this will be marked as unmet.

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33. Documentation that relevant participants were invited to case conference (Contact Form).

We are looking for documentation within a Contact Form note section to indicate that the relevant participants were invited to a case conference.

If there is no documentation to support that relevant participants were invited to a case conference it will be marked as not met.

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34. Documentation showed evidence that case conference recommendations were discussed with the member and incorporated into the ICP as applicable.

Documentation is seen regarding the case conference recommendations being discussed with the member.

The recommendations from the case conference are to be incorporated within the ICP.

If the member refuses to have recommendations part of the ICP, then there needs to be documentation as to why it is not part of the ICP.

If there is no documentation of discussion being held with the member, if no documentation of why recommendations are not incorporated within the ICP, or recommendations are not within ICP, it will be marked as not met.

35. If member did not request ICT, ECM LCM should coordinate an ICT meeting at least twice a year and provide documentation that shows evidence of ongoing information sharing among the member's multidisciplinary care team. If the member has been enrolled in ECM less than a year, this element would be N/A.

If the member does not request ICT meeting, there needs to be detailed documentation within the contact form of continued communication among the ECM team and the members care team.

You required to have at least one informal ICT meeting with the member and multidisciplinary care team while the member is enrolled in ECM.

If there is no documentation seen or no informal ICT meeting is held then it will be marked as not met.

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36. Is there evidence of outreach to the member within 2 days of discharge or agreed upon date if contact made with member prior to discharge? Outreach should include interventions to ensure follow up needs are met.

If the member was hospitalized there needs to be an outreach done within 2 days of discharge or agreed upon date between member and ECM team.

Documentation of this outreach will include interventions to ensure follow up needs are being met.

If there is no outreach done within 2 days of discharge/on the agreed upon date and no documentation it will be marked as not met.

37. Was the Enterprise Transition of Care Assessment completed within 7 business days of discharge? Best practice is face to face visit.

If outreach was requested, it needs to be completed within 7 business days of discharge or at the agreed upon date between the member and ECM team.

Transition of Care assessment is to be completed within 7 business days of discharge.

If outreach is not done within 7 business days or by agreed upon date as requested by the member or if the Transition of Care Assessment is not completed within 7 business days of discharge, it will be marked as not met.

38. Was the ICP updated post hospitalization and shared with member and provider within 14 days of updating the ICP for enrolled members?

ICP to be updated post hospitalization.

ICP is shared with both the member and provider within 14 days of updating the ICP.

If the ICP is not updated post hospitalization or it is not shared within 14 days of updating the ICP to both the member and provider, it will be marked as not met.

39. Evidence of coordination of all services for members during and post care transitions from lower acuity facilities/departments (emergency departments, skills nursing facilities, residential/treatment centers, incarceration facilities, etc. for enrolled members

Documentation is to support the coordination of services during and post care transitions from facilities.

If there is no documentation to support the coordination of services for the member during and post care transition it will be marked as not met.

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40. If there is evidence that a member should be disenrolled from ECM, was the ECM Disenrollment template correctly submitted in CCA?

Documentation would support that a member should be disenrolled from ECM.

ECM staff are to use the disenrollment template and submit within CCA.

If there is no documentation to support that the member should be disenrolled from ECM and if the disenrollment template is not completed and submitted within CCA, it will be marked as not met.

If the member continued to be enrolled this will be marked as not applicable (NA).

41. ICP was closed, including goals, milestones and barriers, using the most appropriate status reasons.

42. If the reason for disenrollment is due to UTC or member no longer wants ECM, was the Post Opt-in UTC or Decline letter sent to the member?

If the member is disenrolled due to becoming UTC or Decline, the post opt-in UTC or Decline letter is to be sent to the member.

ECM Lead Care Manager is to mail out the post opt-in Decline letter to the member before disenrollment of the program.

If the post opt-in Decline letter is unable to be sent due to no address, the ECM Lead is to document within "ECM Disenrollment Reason Additional Information" box to indicate this reason.

If the post opt-in UTC or Decline letter is not sent nor is there documentation to support why it was not sent to the member, it will be marked as not met.

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Audit Notes

We are aware that you will no longer have access to the member's CCA profile once the member becomes inactive. We also understand that certain measures may not apply to grandfathered members.

Please remember to report any CCA issues to MHC ECM inbox: mhc_ecm@molinahealthcare.com so they do not affect your audit results. Additionally, we acknowledge that CLR was implemented on July 1, 2025.

Questions?