Enhanced Care Management (ECM)
Discontinuation of Services Request (FORM E)

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ECM Services may be discontinued as a result of the Member's request or determination by ECM Provider and/or CenCal Health that discontinuation is appropriate (in accordance with the ECM discontinuation criteria listed below). ECM providers must notify CenCal Health upon determination that a member meets the ECM discontinuation criteria. CenCal Health will review the request and notify ECM Provider when to initiate the discontinuation of ECM Services. **ECM provider must notify CCH at least 10 days in advance of service discontinuation, to the extent possible**.

Member and Provider Information

Medi-Cal ID: _____ Member Name: _____

Authorization Number: _____ Date of Birth: _____

ECM Organization Name: _____

Lead Care Manager (LCM) Name: _____ LCM Phone Number: _____

Date ECM Services are intended to be discontinued: _____ **Approval From CCH Required**

Individual Requesting Discontinuation (Please include full name/relationship to Member in Detailed Summary section):

- ◯ ECM Provider
- ◯ Member
- ◯ Parent/Guardian/Authorized Representative: _____
- ◯ Primary Care Provider

Notified the following of Discontinuation:

- ◯ Member
- ◯ Parent/Guardian/Authorized Representative
- ◯ Primary Care Provider

Communication Method:

- ◯ Phone
- ◯ In-Person
- ◯ In Writing
- ◯ Unable to notify Member *(Phone/In-Person/Writing)*

Discontinuation Criteria for Enrolled Members

Please select only one. Then, complete appropriate sections on Pages 2-6.

- ◯ 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 Services
- ◯ The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts
- ◯ The Member is unresponsive or unwilling to engage
- ◯ Member's behavior or environment is unsafe for the ECM Provider
- ◯ Enrolled in Hospice Services
- ◯ Loss of Medi-Cal coverage
- ◯ Deceased
- ◯ Member not reauthorized for ECM Services "only select if CCH denied Authorization Request"
- ◯ Moved out of Country
- ◯ Moved out of the County
- ◯ Incarcerated
- ◯ Member is participating in a duplicate program
- ◯ Switched Health Plans
- ◯ Share of Cost

Discontinuation Reason

☐ The Member has met all care plan goals:

- Copy of updated Care Plan indicating each goal is "Completed, No Longer Needed, or Declined".
- If a copy of the Care Plan (CP) is not included, please describe in detail the goals Member completed (i.e., Member completed diabetes and housing goals to improve health outcomes and is ready to transition out of ECM).

☐ The Member is ready to transition to lower level of care

Member's outstanding needs or unmet goals in ECM can be met through a lower level of Care Management (CM) services.

Provide reason for need to transition to lower level of care and name of new Provider/Agency.

Example: Member has multiple medical conditions and is successfully linked with Primary Care Provider (met goals), and outstanding goal is housing support. Member is linked with Homeless Services Agency and able to transition to lower level of care to address housing needs.

☐ The Member no longer wishes to receive ECM Services

*If you have been **unable to contact Member** please select "Has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts" as the reason for discontinuation.*

Provide reason Member is no longer interested in receiving ECM Services:

List resources provided to Member for support and continuity of care:

Indicate if Member declined resources, as appropriate:

If someone other than the member requested disenrollment, include full name (First, Last Name) and relationship (Parent/Caregiver/Guardian):

☐ The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts

Send summary of the number of unsuccessful attempts to reach Member. Include the time frame and outreach methods (phone/in-person/mail) to reengage Member:

Include efforts made to obtain new contact information:
(i.e., reached out to Primary Care Provider or CenCal Health Member Services to obtain phone number.)

(i.e., Member was contacted 2 times in January via phone and 1 in-person attempt; 4 calls and 2 in-person attempts in February. Called PCP to request new phone number. PCP did not have an updated number for Member.)

☐ Member unresponsive or unwilling to engage

Unwilling to Engage (Non-adherent to ECM Services/Care Plan):

Document unwillingness to engage *(i.e., does not want minimum level of contact per month, based on acuity.)*

- *Does not follow through with CP goals as agreed upon.*
- *Example: Member stated he will be present in-person to meet but has not shown up on several occasions. Or member agreed to answer a call on a scheduled date and time and was not available to answer on several occasions.*
- *Does not communicate at least once per month.*

☐ The Member's behavior or environment is unsafe for the ECM Provider

Describe behavior or environment that was unsafe and include date(s) and location(s):

- *Example: If applicable, did it involve APS, CPS, law enforcement, crisis intervention?*

If applicable, efforts made to meet Member in a safer environment:

The Member's behavior or environment is unsafe for the ECM Provider (cont.)

Options explored for a new Provider who may be able to meet Member need despite the listed behaviors:
(i.e., a Street Outreach Team or County Behavioral Health program who may have resources to engage members in an environment that may not be appropriate for your program.)

Provide list of community resources/supports provided to member for transitional care services.

If unable to link with another provider, document reason:
(i.e., Member declined referrals; Member left program abruptly.)

☐ Enrolled in Hospice Services

Describe how Provider became aware that Member was enrolled in Hospice Services:
(i.e., Member reported, spoke with Hospice Provider.)

Name of Hospice Provider, if known:

Date when Member was enrolled in hospice, if known:

☐ Loss of Medi-Cal coverage

Document last date of ECM service:

Provide details about reason for loss of benefits, if known:

If Member lost Medi-Cal due to not responding to Medi-Cal renewal requirements, document efforts made to assist Member in re-instating their benefits with Department of Social Services (DSS) office.

Include date you attempted to assist Member with reinstating benefits:

☐ Member deceased

Provide the date of death, if known:

Document how the Provider learned of Member's passing:

☐ Member not reauthorized for ECM Services (only select if CCH denied Authorization Request)

No additional documentation required from Provider.

☐ Moved out of country

Provide last date of contact with Member:

Provide information about how to reinstate Medi-Cal and/or how to refer to ECM in future, if Member returns to Santa Barbara/San Luis Obispo Counties:

☐ Moved out of county

Provide date of last contact with Member:

If transferred to a new county (not loss of benefits), document Transition of Care (TOC) efforts.
For example, efforts made to connect Member with Department of Social Services (DSS) office in new area or referral to Enhanced Care Management program in another county.

☐ Incarcerated

Document when you were informed the Member was incarcerated:

Provide County where incarcerated, if known:

Provide date Member was incarcerated, if known:

☐ Member is participating in a duplicate program

Provide details on how you learned Member is participating in a duplicate program:

Provide Name of Agency providing duplicate level of care:

Provide details of coordination with Member/another Provider for Transition of Care:
**Names of Duplicate Programs can be found in the Exclusionary Screening Checklist (Form B) or in the ECM Referral Form (Enrolled in Other Programs and Services).*

☐ Switched Health Plans

Document the date you were informed the Member was enrolled in a new Managed Care Plan (Medi-Cal):

Provide name of new Health Plan, if known:

Provide any coordination of care with new Health Plan, if completed:

☐ Share of Cost

If a member has a Share of Cost, they are not eligible for Enhanced Care Management services.

- *Refer Member to Department of Social Services to discuss Share of Cost.*

Include date you attempted to discuss Share of Cost with Member:

Attach completed ECM Discontinuation Request and supporting documentation to Service Authorization Request using drop-down option "ECM Discontinuation." If Utilization Management requests any additional information, use drop-down option "ECM Additional Documentation."

Submit via Provider Portal: https://web.cencalhealth.org

Enhanced Care Management

Phone Number:
805-562 1698, Option 2

Fax Number:
805-681-3038

Best Practices

- If the Member moves within CenCal Health's service area (Santa Barbara or San Luis Obispo counties) and their current ECM Provider can't serve the new county, complete the Provider Reassignment Form (Form I) instead of the Discontinuation Form if they want to keep receiving ECM services.
- If the Member is being reassigned from one ECM Provider to another, the Discontinuation Form is not needed. The Provider Reassignment Form (Form I) is required.
- Send CenCal Health a copy of the Provider Discontinuation Letter mailed to the Member, if applicable.
- If the Member has a Share of Cost, they are not eligible for Enhanced Care Management.
- Loss of Medi-Cal: Discontinue Member within 60 days of loss of Medi-Cal coverage. Verify eligibility on 1st and 15th of the month to see if Medi-Cal was reinstated for the Member.
- Discontinue Member who is in Skilled Nursing Facility for longer than 60 days. Coordinate with Skilled Nursing Facility Social Worker/Discharge Planner regularly.
- The Member Information File (MIF) informs Providers of Member Medi-Cal renewal date to help Provider ensure Member maintains coverage (i.e., Help Member fill out renewal forms timely). This is the Medical_ Renewal_Date_ column on the MIF File.
- If the Member moves out of county, provide Member with DHCS Managed Care Health Plan Directory information: **https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx**
- If Member is incarcerated, refer to CenCal Health Eligibility screen in Provider Portal and/or CDCR website.
- Inform Member of how to request ECM services in the future, if interested, to the extent possible.