ECM Referral Form

Overview: Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible Members with complex needs. The purpose of this ECM Referral is to collect key information about the Member, so that their MCP can confirm if the Member is eligible for ECM. If the Member is eligible for ECM, their MCP will assign the Member to an ECM Provider who supports the Member's specific Population(s) of Focus.

Eligibility for ECM: To receive ECM, Medi-Cal Members must meet DHCS eligibility criteria for at least one of the Populations of Focus (POF) described in the ECM Referral Form. Members can be eligible for more than one POF, so please review and complete information for all POFs for a Member's age group.

Submitting the ECM Referral Form to the Member's Managed Care Plan (MCP):

Step 1: Verify Member Medi-Cal Eligibility.

Step 2: Complete ECM Referral Form to determine if Member meets in one or more Population of Focus.

Step 3: If based on the responses the Member meets ECM criteria for at least one POF, then send the ECM Referral Form securely through the designated methods listed below. IEHP will review and verify the members eligibility and respond within five (5) business days.

- Email : ECMCareExtenders@iehp.org

ECM Referral Form

Please complete sections 1-6. If there is a required section that you are unable to complete, please contact IEHP Provider Services 909-890-2054 or email ECMCareExtenders@iehp.org for additional support prior to submission.

1. MEMBER INFORMATION ***Asterisk (*) indicates required information.***	
Date of Referral*	
Type of Referral*	☐ Routine ☐ Expedited
Member's Managed Care Plan*	
Member First Name*	
Member Last Name*	
Member Medi-Cal Client Index Number (CIN)	
Managed Care Plan Member ID Number	
Member Date of Birth (MM/DD/YYYY)*	
Member Primary Phone Number*	
Member Preferred Language	☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin ☐ Other
Member Primary Care Provider Name	
Member Residential Address, or If no fixed current address, please list frequently visited location for the Member.	☐ Please check here for: No fixed current address.
Member Residential City	
Member Residential Zip Code	
Member Email	
Best Contact Method for	☐ Phone

ECM Referral Form

1. MEMBER / CAREGIVER / GUARDIAN INFORMATION ***Asterisk (*) indicates required information.***	
Member/Caregiver, if applicable	☐ Email
Best Contact Time for Member/Caregiver	
Parent/Guardian/Caregiver Name, if applicable	
Parent/Guardian/Caregiver Phone Number, if applicable	
Parent/Guardian/Caregiver Email, if applicable	

ECM Referral Form

2. REFERRAL SOURCE INFORMATION	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member*	☐ Medical Provider ☐ Social Services Provider ☐ Other **Please provide additional detail in Section 5 – Additional Comments.**

INTERNAL IEHP ONLY	**Who is the referring department?** ☐ ITC ☐ BHCM ☐ Social and Community Services ☐ Health Navigators **How was Member contacted?** ☐ Phone ☐ Field / In Person

ECM Referral Form

ECM PROVIDERS ONLY	**Does the referring organization recommend that the Member be assigned to it as their ECM Provider?** Please select one of the following: ☐ Yes, our organization should be the Member's ECM Provider ☐ No, our organization recommends this Member is assigned to a different ECM Provider based on their needs. **Please provide additional detail in Section 5 – Additional Comments.** ☐ No, this Member wants an alternative preferred ECM Provider Preferred ECM Care Manager _____ Preferred ECM Provider Organization _____
ECM PROVIDERS WITH PRESUMPTIVE AUTHORIZATION ONLY	**Has the Member already started ECM services?** Please select one of the following: ☐ Yes, this Member has already started ECM services ECM Benefit Start Date (MM/DD/YYYY) _____ ☐ No, this Member has not started ECM services *ECM Benefit Start Date is the date when billable ECM services were first provided to the Member. This does not include outreach services.*

The ECM presumptive authorization policy enables a subset of ECM providers to directly authorize ECM for 30 calendar days, so they can more rapidly initiate ECM services and ensure members receive the care they need. To confirm if you meet eligibility to request presumptive authorization please refer to ECM Policy Guide. See link Figure 5

During the presumptive authorization period, the ECM Provider must submit the ECM Referral form to IEHP for formal authorization to continue to receive reimbursement for services beyond the presumptive authorization timeframe. ECM Providers are encouraged to submit their referral for ECM as soon as possible and no later than five working days before the end of the presumptive authorization period to limit gaps in authorization and reimbursement for ECM services provided to Members.

ECM Referral Form

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

ADULT (AGE 21 OR OLDER) ECM ELIGIBILITY – CHECK THOSE THAT APPLY

If the Member being referred is an adult, please review each indicator and indicate yes to all those that apply across each Population of Focus. ***Please leave blank all indicators that do not apply, to the extent of your knowledge.*** *Please use Section 5 – Additional Comments to note any areas where further MCP review may be warranted. For additional guidance on the ECM POF definitions, please refer to the ECM Policy Guide.*

If you are uncertain if a Member is eligible for ECM, please contact IEHP Provider Services 909-890-2054 or email ECMCareExtenders@iehp.org for additional support prior to submission.

☐ **HOMELESSNESS: Adults Experiencing Homelessness**

(Note: To refer a homeless family to ECM, please use Children/Youth section)

Please confirm the Member meets both of the following criteria:

☐ Member is experiencing Homelessness (unhoused, in a shelter, losing housing in next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence);

AND

☐ Member has at least one complex physical, behavioral or developmental health need (includes pregnancy or post-partum, 12 months from delivery), for which the Member would benefit from care coordination.

☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT UTILIZATION: Adults at Risk for Avoidable Hospital or ED Utilization**

Please confirm the Member meets at least one of the following criteria:

☐ Over the last six months, the Member has had 5 or more emergency room visits that could have been avoided with appropriate care;

AND/OR

☐ Over the last six months, the Member has 3 or more unplanned hospital and/or short-term skilled nursing facility stays that could have been avoided with appropriate care;

☐ **SERIOUS MENTAL HEALTH/SUBSTANCE USE: Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs**

ECM Referral Form

Please confirm Member meets all of the following criteria:

- ☐ Member meets eligibility criteria for, and/or is obtaining services through, at least one of the following:
  - ☐ Specialty Mental Health Services (SMHS) delivered by MHPs: Significant impairment (distress, disability, or dysfunction in social, occupational, or other important activities) OR A reasonable probability of significant deterioration in an important area of life functioning. Eligibility criteria available here: BHIN 21-073
  - ☐ Drug Medi-Cal Organization Delivery System (DMC-ODS): Have at least one diagnosis for Substance-Related and Addictive Disorder with the exception of Tobacco-related disorders and non-substance-related disorders. Eligibility criteria available here: BHIN 24-001.
  - ☐ Drug Medi-Cal (DMC) Program: Have at least one diagnosis for Substance-Related and Addictive Disorder with the exception of Tobacco-related disorders and non-substance-related disorders. Eligibility criteria available here: BHIN 21-071.

  AND
- ☐ Member is actively experiencing at least one complex social factor influencing their health, which may include, but is not limited to: lack of access to food; lack of access to stable housing; inability to work or engage in the community; former foster youth; or history of recent contacts with law enforcement related to mental health or substance use symptoms;

  AND
- ☐ Member meets one or more of the following criteria:
  - ☐ High risk for institutionalization, overdose, and/or suicide
  - ☐ Use crisis services, ERs, Urgent Care or inpatient stays as the primary source of care
  - ☐ 2+ ER visits or 2+ hospitalizations due to Serious Mental Illness or SUD in the past 12 months
  - ☐ Pregnant or post-partum (up to 12 months from delivery)

☐ **JUSTICE INVOLVED: Adults Transitioning from Incarceration within the past 12 months**

(Note: To refer a former foster youth between 18 and 26 to ECM, please use Children/Youth section)

ECM Referral Form

Please confirm Member meets <u>both</u> of the following criteria:

☐ Member is transitioning from a correctional facility (e.g. prison, jail or youth correctional facility), or transitioned from correctional facility within the past 12 months;

AND

☐ Member has a diagnosis of <u>at least one</u> of the following conditions:

- ☐ Mental Illness
- ☐ Substance Use Disorder (SUD)
- ☐ Chronic Condition/Significant Non-Chronic Clinical Condition
- ☐ Intellectual or Developmental Disability (I/DD)
- ☐ Traumatic Brain Injury
- ☐ HIV/AIDS
- ☐ Pregnant or Postpartum (up to 12 months from delivery)

☐ LONG TERM CARE (LTC) INSTITUTIONALIZATION: Adults living in the community who are at risk for LTC Institutionalization

Please confirm the Member meets <u>all</u> of the following criteria:

☐ Member meets at least one of the following criteria:

- ☐ Living in the community and meets Skilled Nursing Facility (SNF) Level of Care criteria. Eligibility criteria available here: 22-CCR-51335
- ☐ Requires lower-acuity skilled nursing, such as time limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness/injury;

AND

☐ Member is actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to: Needing assistance with activities of daily living, communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring)

AND

☐ Member is able to reside continuously in the community with wraparound supports.

☐ NURSING RESIDENTS TRANSITIONING TO COMMUNITY: Adult Nursing Facility Residents Transitioning to the Community

ECM Referral Form

Please confirm the Member meets <u>all</u> of the following criteria:

- ☐ Member is a nursing facility resident who is interested in moving out of the institution

AND

- ☐ Member is a likely candidate to move out of the institution successfully

AND

- ☐ Member is able to reside continuously in the community.

☐ BIRTH EQUITY: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes

Please confirm the Member meets <u>all</u> of the following criteria:

- ☐ Member is pregnant or postpartum (through 12 months period)

AND

- ☐ Member is subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality. As of 2024, Black, American Indian or Alaska Native, and Pacific Islander Members are included in this definition (referring individuals should prioritize Member self-identification).

ECM Referral Form

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

CHILDREN/YOUTH (UNDER 21) ECM ELIGIBILITY OR HOMELESS FAMILIES– CHECK ALL THAT APPLY

If the Member being referred is a child, youth or family (homelessness), please review each indicator and indicate yes to <u>all</u> those that apply across the child/youth Populations of Focus definitions, to help the MCP determine whether the individual qualifies for ECM and understand the child/youth/family's needs as fully as possible. Please leave blank all indicators that do not apply, to the extent of your knowledge.

If you are referring a child/youth who is experiencing homelessness, and their family members or caretakers are also experiencing homelessness and have coverage through Medi-Cal Managed Care, please consider referring all family members/caregivers for ECM services. MCPs are encouraged to work with ECM Providers to serve a family unit together when referred for experiencing homelessness.

If you are uncertain if a Member is eligible for ECM, please contact IEHP Provider Services 909-890-2054 or email ECMCareExtenders@iehp.org for additional support prior to submission.

☐ **HOMELESSNESS: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness**

What is the Member's status?

☐ Member is an unaccompanied child/youth experiencing homelessness

☐ Member is part of a family experiencing homelessness

Please confirm the Member meets <u>at least one</u> of the following criteria:

☐ Child/youth or family with Members under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence)

AND/OR

☐ Child/youth or family is sharing the housing of other persons (i.e. couch surfing) due to loss of housing, economic hardship, or a similar reason; or is living in a motel, hotel, trailer park, or camping ground due to the lack of alternative adequate accommodations; is living in emergency or transitional shelter; or is abandoned in hospital (in hospital without a safe place to be discharged to)

ECM Referral Form

☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT USE: Children and Youth At Risk for Avoidable Hospital or ED Utilization**
Please confirm the Member meets <u>at least one</u> of the following criteria in the last 12 months: ☐ Child/youth has 3 or more emergency room visits that could have been avoided with appropriate care within the last 12 months; **AND/OR** ☐ Child/youth has 2 or more unplanned hospital and/or short-term skilled nursing facility stays that could have been avoided with appropriate care, within the last 12 months.
☐ **SERIOUS MENTAL HEALTH OR SUBSTANCE USE DISORDER: Children and Youth with Serious Mental Health and/or SUD Needs**
Please confirm the Member meets eligibility criteria for and/or is obtaining services through at least one of the following: ☐ Specialty Mental Health Services (SMHS) delivered by MHPs: Members under age 21 qualify to receive all medically necessary SMHS services. Eligibility criteria available here: BHIN 21-073. A child or youth who screens positive for four or more ACES in their primary care practice and meets the access criteria for SMHS services, but has not been linked to care and does not have the family or social support needed to further evaluate/address their needs, qualifies here. ☐ Drug Medi-Cal Organization Delivery System (DMH-ODS): Members under age 21 qualify to receive all medically necessary DMC-ODS services. Eligibility criteria available here: BHIN 24-001. ☐ Drug Medi-Cal (DMC) Program: Covered services provided under DMC shall include all medically necessary SUD services for individuals under 21 years of age. Eligibility criteria available here: BHIN 21-071.
☐ **JUSTICE INVOLVED: Children/Youth Transitioning from a Youth Correctional Facility or Former Foster Youth Between 18 and 26**
Please confirm the Member meets the following criteria: ☐ Member is transitioning/transitioned from a youth correctional setting or adult jail/prison within the last 12 months.

ECM Referral Form

☐ **CCS OR CCS WHOLE CHILD MODEL: Children/Youth Enrolled in California Children's Services (CCS)or CCS WCM with Additional Needs Beyond the CCS Condition**

Please confirm the Member meets all of the following criteria:

☐ Member is enrolled in CCS or CCS WCM;

AND

☐ Member is experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health, former foster youth, and/or substance use symptoms.

☐ **FOSTER CARE: Children/Youth Involved in Child Welfare**

Please confirm the Member meets <u>at least one</u> of the following criteria:

☐ Member is under age 21 and is currently receiving foster care in California;

AND/OR

☐ Member is under age 21 and previously received foster care in California or another state within the last 12 months;

AND/OR

☐ Member is under age 26 and aged out of foster care (having been in foster care on their 18th birthday or later) in California or another state

AND/OR

☐ Member is under age 18 and is eligible for and/or in California's Adoption Assistance Program

AND/OR

☐ Member is under age 18 and is currently receiving or has received services from California's Family Maintenance program within the last 12 months.

ECM Referral Form

☐ **BIRTH EQUITY: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes**
Please confirm the Member meets all of the following criteria: ☐ Member is pregnant or postpartum (up to 12 months from delivery) **AND** ☐ Member is subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality. As of 2024, Black, American Indian or Alaska Native, and Pacific Islander Members are included in this definition (referring individuals should prioritize Member self-identification

ECM Referral Form

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES

Please use the **optional** table below to indicate other programs and services that the Member is receiving under Medi-Cal. Some Medi-Cal services may require coordination with ECM. Because other Medi-Cal services may offer support similar to ECM, Members may be excluded from receiving ECM and these similar services at the same time. The Managed Care Plan will review the information below and make a determination on the Member's eligibility for ECM. The Managed Care Plan is responsible for determining eligibility for ECM, not the referring individual.

If there are any other care management or coordination program(s) in which the Member is enrolled, to the extent known to the referring individual, that would require coordination with ECM (such as California Children's Services, Targeted Case Management within Specialty Mental Health Services, etc.) please share in Section 5 – Additional Comments. Please leave blank all elements that do not apply to the extent of your knowledge.

PROGRAMS	
☐ Dual Eligible Special Needs Plan (D-SNP)	☐ Hospice
☐ Fully Integrated Special Needs Plans (FIDE - SNPs)	☐ Program For All Inclusive Care for the Elderly (PACE)
☐ Multipurpose Senior Services Program (MSSP)	☐ Self-Determination Program for Individuals for Individuals with I/DD
☐ Assisted Living Waiver (ALW)	☐ California Community Transitions (CCT)
☐ Home and Community-Based Alternatives (HCBA) Waiver	☐ HIV/AIDS Waiver

ECM Referral Form

5. ADDITIONAL COMMENTS:	
Please use this section to provide additional comments on Sections 1- 4, as needed.	

6. SUBMISSION INFORMATION & NEXT STEPS
By submitting this form, the referring individual attests to the best of their knowledge that the information in the form is correct. ☐ **I Attest** **Please submit the completed ECM Referral Form to the Member's MCP via secure email to ECMCareExtenders@iehp.org. After submission, MCPs will make an ECM authorization decision within five business days. If the Member is eligible, an ECM Provider will reach out to the Member to confirm interest in ECM and enroll in services.**