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 : <u>ECMCareExtenders@iehp.org</u>

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

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

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	

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	Medical Provider
Member*	Social Services Provider
	 Other Please provide additional detail in Section 5 – Additional Comments.

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

	Does the referring organization recommend that the Member be assigned to it as their ECM Provider? Please select one of the following: U Yes, our organization should be the Member's ECM Provider
ECM PROVIDERS ONLY	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
	Has the Member already started ECM services?
	Please select one of the following:
ECM PROVIDERS WITH PRESUMPTIVE	Yes, this Member has already started ECM services
AUTHORIZATION ONLY	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.

3.	MEMBER	ECM ELIGIBILITY	Y BY POPULATION OF FOCUS	
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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 <u>all</u> 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 <u>ECM Policy</u> <u>Guide</u>.

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

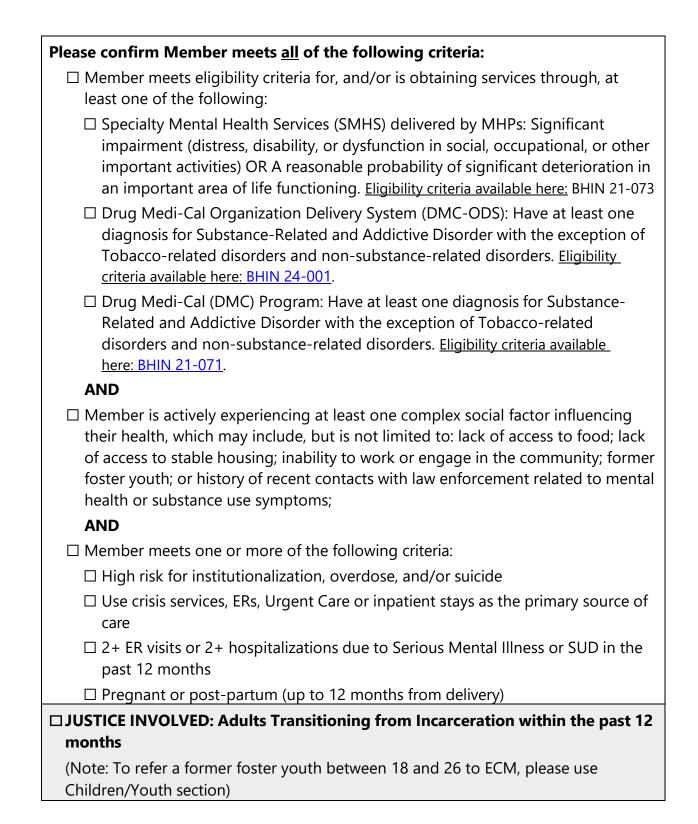
Please confirm the Member meets at least one of the following criteria:

□ 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



Please confirm Member meets both 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)
\Box 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 all 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: <u>22-CCR-51335</u>
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

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

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?

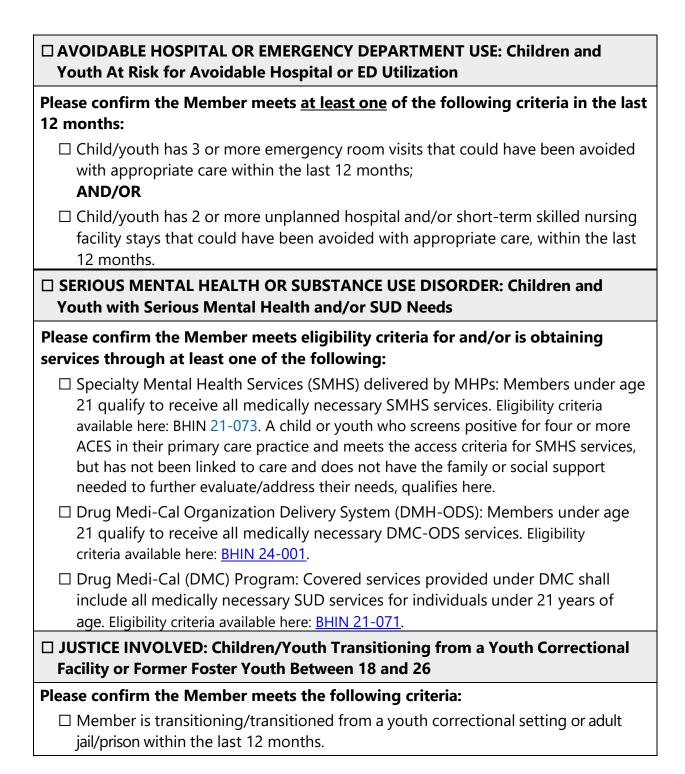
- □ Member is an unaccompanied child/youth experiencing homelessness
- □ Member is part of a family experiencing homelessness

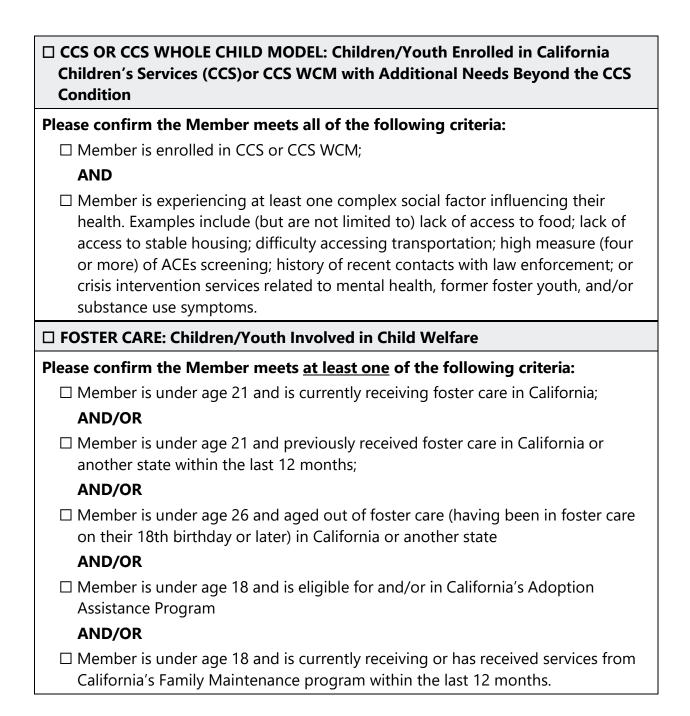
Please confirm the Member meets <u>at least one</u> of the following criteria:

□ 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)





□ 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

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

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 <u>ECMCareExtenders@iehp.org</u>. 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.