Enhanced Care Management (ECM)
Member 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): ECM referrals should be submitted to the Member's Managed Care Plan by [MCP may include Plan-specific instructions here. MCP should include contact information for the member to ask additional questions].

ECM REFERRAL FORM TEMPLATE - ADULT

Please complete sections 1-6.

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):	
Member Care Plan Member ID Number	
Members Date of Birth (MM/DD/YYYY) *	
Member Primary Phone Number*:	
Member Preferred Language*:	
Member Primary Care Provider Name	
Member Residential Address	☐ Please check here for: No fixed current address. If available, please list frequently visited location for the Member
Member Residential City	
Member Residential Zip Code	
Member Email	
Best Contact Method for Member/Caregiver, if applicable	☐ Phone ☐ 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	
Referrer Individual Phone Number*	
Referrer Individual Email Address*	
Referring Individual Relationship to Member*	☐ Provider ☐ Social Services Provider ☐ Other **Please provide additional detail in Section 5 – Additional Comments.**
COMMUNITY PARTNERS (NON-ECM PROVIDERS) ONLY	**Does the Member have a preferred ECM Provider?** Please select one of the following: ☐ Yes, this Member has a preferred ECM Provider Preferred ECM Care Manager: _____ Preferred ECM Provider Organization: _____ ☐ No, this Member does not have a preferred ECM Provider
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.*

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 ad ult, 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 the Member's MCP at MHC_ECM@Molinahealthcare.com.

☐ **HOMELESSNESS: Adults Experiencing Homelessness w/ Family**
☐ **HOMELESSNESS: Adults Experiencing Homelessness w/out Family**

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;

OR

☐ [MCP-specific criteria approved by DHCS, if different from A an d B].

Please provide additional detail in Section 5 – Additional Comments.

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

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.

☐ 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.

☐ 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.

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**

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 12months.

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
- ☐ 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**

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).

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES (OPTIONAL)

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 additional information 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 Elderly (PACE)
☐ Multipurpose Senior Services Program (MSSP)	☐ Self-Determination program 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 comment 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.

Please submit the completed ECM Referral Form to the Member's MCP via Email at MHC_ECMReferrals@Molinahealthcare.com. 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.