LA County Enhanced Care Management (ECM) Benefit Member Referral Form

ECM is a Medi-Cal benefit that provides comprehensive care management services to Medi-Cal members with complex health and/or social needs. Members enrolled in ECM will primarily receive in-person care management services that will be provided in the member's community by contracted ECM Provider agencies who serve the member's specific Population of Focus.

*To be eligible for ECM, members must qualify as one or more of the identified **ECM Populations of Focus** and are not enrolled in duplicative services (as defined in the **ECM Exclusionary Screening Checklist**).*

There are 3 steps to the ECM screening and referral process:

- **Step 1:** Complete the ***Population of Focus Screening Checklist*** to confirm member eligibility in **one or more** Populations of Focus.
- **Step 2:** Complete the ***Exclusionary Screening Checklist* as a 2nd step** to verify member eligibility.
- **Step 3:** If you determine the member to be eligible for the ECM benefit based on ***both Screening Checklists,*** complete and submit the ***ECM Referral Form*** and ***Population of Focus Screening Checklist*** to the Managed Care Plan**.** To expedite the review and approval process, ***please also submit applicable supporting documentation as evidence of the member meeting ECM criteria***. Send securely through the Managed Care Plan's designated method listed below. The Exclusionary Screening Checklist is not required to be submitted. The Managed Care Plan will review and verify the member's eligibility and respond within one week.

Health Plan	ECM Provider Communication Method	Community Provider (Non-ECM Provider) Communication Method
☐ Anthem Blue Cross	*Submit via* https://providers.anthem.com	*Call* 888-285-7801 (TTY 711); *mention ECM*
☐ Blue Shield Promise Health Plan	*Submit via SFTP*	*Submit via secure email:* ECM@blueshieldca.com
☐ Health Net	*Submit via secure email*: Health_Homes_Program@healthnet.com *Please note underscores in email address*	*Submit via secure email:* Health_Homes_Program@healthnet.com *Please note underscores in email address*
☐ Kaiser Permanente	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*
☐ L.A. Care Health Plan	*Submit through your assigned SFTP or via secure email* ECMMembership@lacare.org	*Submit via secure email* ECMMembership@lacare.org *or secure fax* (213) 438-5694
☐ Molina Healthcare of California	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*

Asterisk (*) indicates required information.

REFERRAL SOURCE INFORMATION			
Internal Referring Department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Member Svcs ☐ Other:			
~~External~~ Referral By* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ SNF ☐ DHS ☐ DMH ☐ DPH ☐ Other:			
~~Date of Referral~~:*			
Referring Organization Name:*			
Referring Individual Name & Title:*			
Referrer Phone Number:*			
Referrer Email Address:*			
Has the member expressed interest in opting-into ECM?	☐Yes, and I have already discussed the program with the member. Member's preference of ECM Provider, if known: _____ ☐No, I will validate ECM eligibility prior to discussing ECM with member		
Is the member transitioning their ECM services due to a change in their health plan? (COC)**	☐ Yes ☐ No Please provide previous ECM provider name: _____ Please provide previous CA Medi-Cal health plan name: _____ Please provide last day member worked with previous ECM Provider: _____		
MEMBER INFORMATION			
Member Name:*			
Member Medi-Cal Client ID # (CIN):*		Member Date of Birth:*	
Member Address:			
Member Primary Phone Number:*		Best Contact Time/Location:	
Member Preferred Language:*			
Caregiver Name & Role/Title:		Caregiver Phone/Email:	
Parent/Guardian, if applicable:		Parent/Guardian Phone/Email:	

MEMBER'S ECM ELIGIBILITY *(Complete, refer to, and attach ECM Population of Focus Screening Checklist)* **Check all that Apply***	
☐	1. Individuals and Families Experiencing **Homelessness**
☐	2. Adult **High Utilizers** with Frequent hospital or ER Admissions
☐	3. Individuals Transitioning from **Incarceration**
☐	4. Adults with **SMI/SUD** and other Health Needs
☐	COC – only applies to members transitioning from ECM with another CA Medi-Cal health plan**

EXCLUSIONARY CRITERIA *(Complete and refer to ECM Exclusionary Screening Checklist – do not attach)* **BOTH boxes** must be checked for ECM member eligibility*

☐ I attest that the member is **not enrolled in programs that exclude** the member from ECM eligibility If member *is* enrolled in an ECM duplicative program, member is **opting** for **ECM *instead of*** the other program. ○ **Other Program(s):** ○ **Other Program(s) disenrollment date:** If the member is enrolled in a Program that allows them to **concurrently** receive ECM services (per the Exclusionary Checklist "wrap" program section), **note Program(s):**

ADDITIONAL COMMENTS: (i.e. PCP or support person name and contact if applicable)	

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LA County Enhanced Care Management (ECM) Benefit Populations of Focus Screening Checklist

The ECM Benefit provides comprehensive care management services to 4 different Populations of Focus with the goal to improve the health and social outcomes of the ECM-enrolled member.

Medi-Cal members are eligible for the ECM Benefit if they meet the ECM Populations of Focus eligibility criteria as defined in this checklist ***and*** *are not enrolled in duplicative services (as defined in the Exclusionary Checklist).*

There are 3 steps to the ECM screening and referral process:

- **Step 1:** Complete this ***Population of Focus Screening Checklist*** to confirm member eligibility for **one or more** Populations of Focus.
- **Step 2:** Complete the ***Exclusionary Screening Checklist*** **as a 2nd step** to verify member eligibility.
- **Step 3:** If you determine the member **to be eligible for ECM** based on ***both Screening Checklists***, complete the ***ECM Referral Form*** and send securely to the member's Managed Care Plan for review, with the completed ***Population of Focus Screening Checklist also attached.*** To expedite the review and approval process, ***please also submit applicable supporting documentation as evidence of the member meeting ECM criteria***. Note, the Exclusionary Checklist is not required as an attachment.

Populations of Focus Screening Checklist

ECM Population of Focus

1. ☐ Individual and/or family is **experiencing homelessness*** **AND**

☐ has **at least one** complex **physical, behavioral, or developmental** health need (*please note in Conditions Table on page 3 below) with **inability to successfully self-manage** for whom **coordination of services** would likely result in **improved health outcomes *AND/OR* decreased utilization** of high-cost services.

**DHCS defines homelessness as one of the following:*

- *An individual or family who lacks adequate nighttime residence*
- *An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation*
- *An individual or family living in a shelter*
- *An individual exiting an institution to homelessness*
- *An individual or family who will imminently lose housing in next 30 days*
- *Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes*
- *Victims fleeing domestic violence*

If **BOTH** boxes above are checked, member is eligible

2.	**Adult High Utilizers** are individuals, who **in a six-month period,** with
	☐ **5 or more emergency** room visits **AND/OR** ☐ **3 or more** unplanned **hospital** admissions **AND/OR** ☐ **3 or more short-term skilled nursing facility stays** **AND** any of the above could have been avoided with appropriate outpatient care or improved treatment adherence If **ONE or MORE** of these boxes are checked in this section, member is eligible
3.	Adults with **Serious Mental Illness or Substance Use Disorder** (*please note in Conditions Table on page 3 below) who meet the eligibility criteria for participation in or obtaining services through
	☐ the County Specialty Mental Health (SMH) System **AND/OR** ☐ the Drug Medi-Cal Organized Delivery System (DMC-ODS) **AND** If **ONE** of the 2 boxes above are checked in this section, continue in this section ☐ Actively experiencing **one complex social factor influencing their health,** e.g., Food, Housing, Employment insecurities, History of ACES/trauma, History of recent contacts with law enforcement related to SMI/SUD, Former foster youth, and/or (specify) _____, **AND** ☐ Meet 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 sole source of care • 2+ ED visits or 2+ hospitalizations due to SMI or SUD in the past 12 months • Pregnant or post-partum (12 months from delivery) If **BOTH** boxes above (1. complex social factors and 2. additional criteria) are checked in this section, member is eligible

4. ☐ **Individuals who are transitioning from incarceration** or transitioned from incarceration within the **past 12 months AND**
☐ Have at least one of the following conditions (*please note specifics in Conditions Table below) ☐ Chronic mental illness* ☐ Substance Use Disorder (SUD)* ☐ Chronic disease (e.g., hepatitis C, diabetes)* ☐ Intellectual or developmental disability* ☐ Traumatic brain injury* ☐ HIV/AIDS ☐ Pregnancy If **BOTH** boxes in this section are checked, member is eligible

*Conditions Table: For Reference Only

There may be qualifying conditions not listed in this table. Please list condition in the "Other, please note:" field

Complex Physical, Behavioral Health and Developmental Conditions *(Check all that apply)*	
Physical Health	
☐Asthma	☐Dementia requiring assistance with IADLs
☐Chronic Kidney Disease	☐Diabetes (Insulin-dependent) poorly controlled
☐Chronic Liver Disease	☐History of stroke or heart attack
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐Hypertension (poorly controlled)
☐Congestive Heart Failure (CHF)	☐Traumatic Brain Injury (TBI)
☐Coronary Artery Disease	☐Other, please note:
Behavioral Health	
☐Bipolar disorder	☐Psychotic disorders, including schizophrenia
☐Major Depressive Disorder	☐Substance Use Disorder, please specify:
☐Other, please note:	
Developmental	
☐Intellectual/Developmental Disability	☐Other, please note:

Summary of ECM Eligibility for Managed Care Plan Reference

Member's Eligible Population(s) of Focus *(Check all that apply)*	
☐	1. Individuals Experiencing **Homelessness**
☐	2. **Adult High Utilizers** with frequent hospital, skilled nursing facility or ER Admissions
☐	3. Individuals with **SMI/SUD** and other Health Needs
☐	4. Individuals Transitioning from **Incarceration**

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LA County Enhanced Care Management (ECM) Benefit Exclusionary Screening Checklist

DHCS outlined approaches to program coordination and the prevention of non-duplication with ECM services: ***Absolute, Duplicative, and Wrap.***

There are 3 steps to the screening and referral process:

- **Step 1**: Complete the ***Population of Focus Screening Checklist*** to confirm member eligibility for **one or more** Populations of Focus.
- **Step 2**: Complete this ***Exclusionary Screening Checklist*** **as a 2nd step**
  - To confirm eligibility
  - To identify duplicative programs for which the member must choose, and
  - To identify potential programs that the member can be enrolled in while also in ECM, which will require coordination of services
- **Step 3**: If you determine the member **to be eligible for ECM** based on ***both Screening Checklists***, complete the ***ECM Referral Form*** and send securely to the member's Managed Care Plan for review, with the completed ***Population of Focus Screening Checklist also attached.*** Note, the Exclusionary Checklist is not required as an attachment.

Exclusionary Screening Checklist

Active Medi-Cal

Individual must have active Medi-Cal status and assigned to a Managed Care Plan.

1. ☐ Non-active Medi-Cal
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

2. ☐ Fee-for-Service Medi-Cal
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

Absolute Exclusion Criteria

Medi-Cal beneficiaries enrolled in the programs below are excluded from ECM.

3. ☐ Cal MediConnect
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

4. ☐ Hospice
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

5. ☐ Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

6. ☐ Program for All Inclusive Care for the Elderly (PACE)
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

Duplicative Programs – Either ECM or Other Program

Members who are enrolled in the below duplicative programs have a choice of continuing enrollment in these programs or enrolling in ECM. The member maintains the right to choose or switch between ECM and other duplicative care management programs. We encourage members to choose the program that best meets their needs.

7. Member is currently enrolled in one of the following **1915 Waiver Programs:**
   - ☐ Multipurpose Senior Services Program (MSSP)
   - ☐ Assisted Living Waiver (ALW)
   - ☐ Home and Community-Based Alternatives (HCBA) Waiver
   - ☐ HIV/AIDS Waiver
   - ☐ HCBS Waiver for Individuals with Developmental Disabilities (DD)
   - ☐ Self-Determination Program for Individuals for Individuals with I/DD

   If a box is checked, **STOP.** Member has a choice to continue in their existing 1915 Waiver program or switch to ECM. Please consult with the 1915 Waiver program if possible.
   If box is not checked, move on to next question.

8. Member is currently enrolled in one of the following **Managed Care Programs**:
   - ☐ Basic Case Management
   - ☐ Complex Case Management

   If a box is checked, **STOP.** Member has a choice to continue in their existing Case Management program or switch to ECM. Please consult with Case Management program if possible.
   If box is not checked, move on to next question.

9. Member is currently enrolled in one of the following **Other Programs:**
   - ☐ California Community Transitions (CCT)

   If box is checked, **STOP.** Member has a choice to continue in their existing CCT program or switch to ECM. Please consult with the CCT program if possible.
   If box is not checked, move on to next question.

ECM as a "Wrap" – Can be in Both Programs

Members can be enrolled in **both** ECM and the other program. ECM enhances and coordinates across other care/case management programs. These programs are considered to be complementary to ECM.
The below programs are not exclusionary for ECM. Knowledge of the member's "wrap" programs will require coordination of care activities by the ECM provider.

10. Member is currently enrolled in one of the following **Non-Managed Care Programs**:
    - ☐ California Children's Services (CCS)
    - ☐ County-based Targeted Case Management (TCM)
    - ☐ Specialty Mental Health (SMHS) TCM
    - ☐ SMHS Intensive Care Coordination for Children (ICC)
    - ☐ Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

11. Member is currently enrolled in one of the following **Managed Care Programs**:
    ☐ CCS Whole Child Model
    ☐ Community Based Adult Services (CBAS)

12. Member is currently receiving coverage for Members **Dually Eligible for Medicare and Medicaid**. *Note: Dually eligible members can receive ECM if they meet ECM Population of Focus criteria*
    ☐ Dual Eligible Special Needs Plans (D-SNPs)
    ☐ D-SNP Look-alike Plans
    ☐ Other Medicare Advantage Plans
    ☐ Medicare FFS

13. Member is currently enrolled in one of the **Other Programs:**
    ☐ AIDS Healthcare Foundation Plans
    ☐ Adult Full Service Partnership (FSP) *Note: Recommend ECM Providers coordinate with FSP programs to ensure non-duplication of services.*

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