Enhanced Care Management Program

Phone # **1-800-391-2000** (Option **4**)
Fax: **(661) 473-7501**
Email: **ECMoutreachspecialist@khs-net.com**

ECM Referral Form

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 *Kern Family Health Care (KFHC)* may confirm if the Member is eligible for ECM. If the Member is eligible for ECM, KFHC 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 KFHC:
ECM referrals should be submitted to KFHC by faxing securely to **(661) 473-7501** or by emailing securely to **ECMoutreachspecialist@khs-net.com**. Should there be additional questions, please contact the ECM department at 1-800-391-2000, option 4. Members, caregivers, and family members do not have to use this form and can just call KFHC to refer a Member to the ECM program.

Please note, per DHCS policy, KFHC may not require any additional documentation (i.e. Supplemental checklists, ICD-10 codes, Treatment Authorization Request forms, etc.) in order to authorize ECM services.

ADULTS

Please complete sections 1-6. If there is a required section that you are unable to complete, please contact the KFHC ECM department for additional support prior to submission at 1-800-391-2000 option 4.

1. MEMBER INFORMATION - Asterisk (*) indicates required information to be completed.	
Date of Referral*	
Type of Referral*	☐ Routine ☐ Urgent
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	
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 (Phone or Email)	☐ 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 - Asterisk (*) indicates required information to be completed.	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Full Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member* (please select one)	☐ Medical 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: _____

2. REFERRAL SOURCE INFORMATION

ECM PROVIDERS WITH PRESUMPITVE 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 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 KFHC review may be warranted. For additional guidance on the ECM POF definitions, please refer to the ECM Policy Guide https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf*

If you are uncertain if a Member is eligible for ECM, please contact KFHC at 1-800-391-2000 opt. 4

☐ **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 (1) 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.

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**

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

Please confirm Member meets all 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 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 at least one 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 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
- ☐ 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

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

☐ 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. KFHC will review the information below and make a determination on the Member's eligibility for ECM. KFHC 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.

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES (OPTIONAL)

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 for 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 Kern Family Health Care's Enhanced Care Management Team by one of the two following methods:
Fax to 661-473-7501 or securely email to ECMoutreachspecialist@khs-net.com

After submission, KFHC will make an ECM authorization decision within five (5) 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.

END of Adult ECM Referral Form

CHILD/YOUTH

Please complete sections 1-6. If there is a required section that you are unable to complete, please contact the KFHC ECM department for additional support prior to submission at 1-800-391-2000 option 4.

1. MEMBER INFORMATION - Asterisk (*) indicates required information to be completed.	
Date of Referral*	
Type of Referral*	☐ Routine ☐ Urgent
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	
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 (Phone or Email)	☐ 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 - Asterisk (*) indicates required information to be completed.	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Full Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member* (please select one)	☐ Medical 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: _____

2. REFERRAL SOURCE INFORMATION	
ECM PROVIDERS WITH PRESUMPITVE AUTHORIZATION ONLY	**Does the Member have an ECM Benefit Start Date?** Please select one of the following: ☐ **Yes**, this Member has an ECM Benefit Start Date. ECM Benefit Start Date (MM/DD/YYYY) _____ ☐ **No**, this Member does not have an ECM benefit Start Date. *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
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 KFHC 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 KFHC, please consider referring all family members/caregivers for ECM services. KFHC works 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 KFHC at 1-800-291-2000 opt. 4 to discuss further.***
☐ **HOMELESSNESS: Homeless Families or Unaccompanied Children/Youth 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).
☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT USE: Children and Youth At Risk for Avoidable Hospital or ED Utilization**

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

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.

☐ Drug Medi-Cal Organization Delivery System (DMH-ODS): Members under age 21 qualify to receive all medically necessary DMC-ODS services.

☐ Drug Medi-Cal (DMC) Program: Covered services provided under DMC shall include all medically necessary SUD services for individuals under 21 years of age.

☐ JUSTICE INVOLVED: Children/Youth Transitioning from a Youth Correctional Facility

Please confirm the Member meets the following criteria:

☐ Member is transitioning/transitioned from a youth correctional setting within last 12 months.

☐ 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 <u>all</u> 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.

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

☐ **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 (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. KFHC will review the information below and make a determination on the Member's eligibility for ECM. KFHC 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 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 for 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 Kern Family Health Care's Enhanced Care Management Team by one of the two following methods:
Fax to 661-473-7501 or securely email to ECMoutreachspecialist@khs-net.com

After submission, KFHC will make an ECM authorization decision within five (5) 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.

END of Child/Youth ECM Referral