Sacramento 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. This step is not needed for Kaiser Permanente referrals.
- **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
☐ Aetna Better Health of California	*Submit via secure email:* ABHCAEnhancedCareManagment@AETNA.com	*Submit via secure email:* ABHCAEnhancedCareManagment@AETNA.com
☐ Anthem Blue Cross	*Submit via Anthem Provider Portal: https://providers.anthem.com or secure fax: 844-429-9626 or secure email: CalAimreferrals@anthem.com*	*Call* 800-407-4627 (TTY 711); *mention ECM*
☐ Health Net	*Submit via Health Net's Provider Portal* provider.healthnetcalifornia.com *or secure fax:* 800-743-1655	*Submit via secure fax:* 800-743-1655
☐ Kaiser Permanente	*Submit via secure email:* REGMCDURNs-KPNC@kp.org *with "ECM Referral" as the subject line*	*Submit via secure email:* REGMCDURNs-KPNC@kp.org *with "ECM Referral" as the subject line*
☐ 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:*	
Reason for Referral (Required only for Kaiser Permanente Referrals)	
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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