HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

Enhanced Care Management Adult 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 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.

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 applicable POFs for a Member's age group.

Please complete sections 1-6 of this form as a fillable PDF, then submit as outlined in section 6. For assistance completing the form or eligibility questions, please contact HPSM Care Coordination/Integrated Care Management by calling 650-616-2060 or visiting www.hpsm.org/provider/calaim/ecm.

Asterisk (*) indicates required information.

Type of Referral:* ☐ Routine ☑ Urgent **Date of Referral:***

SECTION 1 MEMBER INFORMATION

Member's Managed Care Plan: Health Plan of San Mateo

First Name:* _____ **Last Name:*** _____

Medi-Cal Client Index Number (CIN): _____ **HPSM Member ID #:** _____

Date of Birth:* _____ **Phone:*** _____ **Primary Language:** _____

Name of Primary Care Provider: _____

MEMBER/PARENT/CAREGIVER CONTACT INFORMATION

Member has no fixed residential address (If available, please enter a frequently visited location)

Member's Address: _____

Member's Email: _____

Parent/Caregiver's Name (if applicable): _____

Parent/Caregiver Address (if applicable): _____

Parent/Caregiver Phone (if applicable): _____

Parent/Caregiver Email (if applicable): _____

Preferred Method of Contact: Phone Email **Best Time to Contact:** _____

SECTION 2 BEGINS ON NEXT PAGE ▶

SECTION 2 REFERRAL SOURCE INFORMATION

Name of Referring Organization:* _____ **NPI #:** _____

Name of Referring Individual:* _____ **Title:** _____

Phone:* _____ **Email Address:*** _____

Relationship to Member:* Medical Provider Social Services Provider

Other (Please provide additional detail in Section 5 – Additional Comments)

NON-ECM PROVIDERS AND COMMUNITY PARTNERS 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?

☐ **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

The ECM Benefit Start Date is the date when billable ECM services were first provided to the Member. This does not include outreach services.

Does the Member have an ECM Benefit Start Date?

☐ **Yes**, this Member has an ECM Benefit Start Date

ECM Benefit Start Date: _____

☐ **No**, this Member does not have an ECM Benefit Start Date

SECTION 3 BEGINS ON NEXT PAGE ▶

SECTION 3 MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

Adult (Age 21 Or Older) ECM Eligibility

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 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 HPSM Care Coordination/Integrated Care Management.

☐ **HOMELESSNESS: Adults Experiencing Homelessness**

Note: To refer a homeless family to ECM, please use the Children/Youth referral form.

Please confirm the Member meets <u>both</u> of the following criteria. Check all that apply:

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 USE: Adults at Risk for Avoidable Hospital or ED Utilization**

Please confirm the Member meets <u>at least one</u> 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 OR SUBSTANCE USE DISORDER: Adults with Serious Mental Health and/or Substance Use Disorder Needs**

Please confirm Member meets <u>all</u> 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

SECTION 3 CONTINUES ON NEXT PAGE ▶

✔ 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 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)

SECTION 3 CONTINUES ON NEXT PAGE ▶

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. Select all that apply:

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).

SECTION 4 BEGINS ON NEXT PAGE ▶

SECTION 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.

Dual Eligible Special Needs Plan (D-SNP)	Hospice
Fully Integrated Special Needs Plans (FIDE - SNPs)	Program For All Inclusive Care for the Elderly
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

SECTION 5 BEGINS ON NEXT PAGE ▶

SECTION 5 ADDITIONAL COMMENTS

Please use this section to provide additional comments from Sections 1 through 4, as needed.

SECTION 6 BEGINS ON NEXT PAGE ▶

SECTION 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 HPSM Care Coordination/Integrated Care Management by email (preferred method) or fax:

Email: CareCoordinationRequests@hpsm.org
Fax: 650-829-2047

After submission, HPSM will make an ECM authorization decision within five business days for routine requests or within 72 hours for urgent requests. If the Member is eligible, an ECM Provider will reach out to the Member to confirm interest in ECM and enroll in services.

Print Email