Policy and Procedure No: CM 18.5	**Revision No: 5**
Division: Care Management	
Department: Care Management	
Title: PHC-CA ECM Enrollee Identification	
Effective Date: 1/1/2022	
Supersedes Policy No: CM 18.0, CM 18.1, CM 18.2, CM 18.3, CM 18.4	
Reviewed/Revised by: Tiffany Jarrett	**Review/Revision Date: 1/3/2025**
Approving Committee: Utilization Management Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe the process of PHC California (the Health Plan) to identify enrollees who qualify for Enhanced Care Management (ECM).

Policy:

1. The Health Plan proactively identifies enrollees who meet criteria for ECM Adult Populations of Focus (POF), including:

    A. Individuals experiencing homelessness

    B. Individuals at risk for avoidable hospital or Emergency Department (ED) utilization

    C. Individuals with serious mental health and/or substance use disorder (SUD) needs

    D. Individuals transitioning from incarceration

    E. Adults living in the community and at risk for long-term care (LTC) institutionalization

    F. Adult nursing facility residents transitioning to the community

    G. Individuals aged 21-26 who have aged out of foster care (subset of Children and Youth Involved in Child Welfare POF)

    H. Pregnancy, postpartum and birth equity

    Note: The Health Plan does not enroll or serve populations under the age of twenty-one (21). Therefore, with the exception of Children and Youth aged out of foster care as noted above (21-26 years of age), POFs consisting of children only are not applicable.

2. The Health Plan considers the members' healthcare utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health and LTSS needs.

3. The Health Plan offers ECM to members who meet Adult Population of Focus area criteria in-full or partially.

4. The Health Plan excludes members from consideration that are enrolled or participate in the following programs:

A. 1915(c) waivers:

i. Multipurpose Senior Services Program (MSSP)

ii. Assisted Living Waiver;

iii. Home and Community-Based Alternatives (HCBA) Waiver;

iv. HIV/AIDS Waiver;

B. Family Mosaic Project

C. California Community Transitions (CCT) Money Follows the Person (MFTP)

D. Basic or complex case management

5. The Health Plan accepts requests for ECM services from enrollees and/or their family member(s), guardians, authorized representatives, caregivers, and/or authorized support person(s), ECM providers, other providers and community-based entities, including those contracted to provide Community Supports (ILOS) services.

6. The Health Plan educates and provides on-going education to all Care Coordination staff regarding ECM services, including but not limited to, how to refer/ request ECM services for a member, the scope ECM services, and updates to the ECM program based on the Plan's data review or DHCS identified updates.

7. The Health Plan provides presumptive authorization for ECM in the following situations:

A. Enrollees are referred for ECM by their RN Care Team Manager

B. Enrollees are identified as eligible for ECM by the Health Plan's internal data

C. Enrollees are referred for ECM by an ECM provider serving the specific Populations of Focus as described in the August 2024 CalAIM ECM Policy Guide

8. As described in the CalAIM ECM Referral Standards and Form Templates guidance published August 2024, the Health Plan uses the DHCS-provided ECM Referral Form Template for its ECM Referral and Authorization Form (Attachment A).

Procedure:

1. The National Director of Care Coordination, ECM RN Care Manager or designee identifies members who meet criteria for ECM Populations of Focus in the following manner:

Category	Identification Data Source(s)	Review/Report Criteria
Experiencing Homelessness	claims/encounter data, survey, EMR, SDOH	Diagnosis, chronic co-morbidities, Self-reported, AOR reported, Health Care Professional identification, History of homelessness,

High Utilizers	Claims/encounter data, survey, HRA	Diagnosis, Admission Payment > $200,000 and/or multiple admissions totaling $200K over a 3-month period, chronic co-morbidities, > 5 ER visits in a 6-month period, and/or > 2-3 IP admissions in a 6-month period
Serious Mental Illness (SMI) or substance use disorder (SUD)	Claims/encounter data, survey, HRA, EMR, SDOH	Diagnosis, Self-reported on survey, Magellan Mental Health program enrollment, ED/Urgent Care/IP admission for mental health, clinical review by member of ECM team
Transitioning from Incarceration	Surveys, Case management notes	Reported by member, AOR, or County/Legal representative.
Individuals at risk for institutionalization who are eligible for long-term care services	Claims/encounter data, survey	Authorization/admission for placement at a facility. Requires clinical review by a member of ECM team.
Nursing facility residents transitioning to the community	Claims/encounter data, survey, authorization, Care Manager team member completed survey/case notes	Member is currently residing at a nursing facility. Member, AOR, or facility reports members desire to transition to community. Requires clinical review by a member of ECM team.
Children and Youth	Claims/encounter data, survey, HRA, EMR, SDOH	Aged out of foster care (21-26 years of age – having been in foster care on their 18th birthday or later) in CA or another state, Requires clinical review by a member of ECM team. Assessment to determine needs and resources conducive to this population of focus.
Pregnant and postpartum enrollees	Claims/encounter data, survey, HRA, EMR	HIV-positive pregnancies are by default considered high risk.

Note: data is reviewed to verify validity of enrollment into ECM program. The Director of Care Coordination, ECM RN Care Manager or designee updates and modifies reports as data is received and the program further develops.

2. The National Director of Care Coordination, ECM RN Care Manager or designee utilize all available data resources to identify potential members that can benefit from ECM. Data sources include but are not limited to the following:

    a. Eligibility files: indicating AID Code and LTC eligibility reported on DHCS 834 enrollment file and CMS DTRR for dual eligible members

    b. Enrollment review: Information collected during eligibility verification process for new enrollees

    c. Encounter data: any detailed health information submitted to the Health Plan by DHCS or first tier downstream entity vendors e.g., Liberty Dental, Magellan, and VSP (AHI)

    d. Utilization/claims data: Utilization of inpatient, skilled nursing, and emergency services received on claims stored in claims adjudication system of the Plan's enrollment, provider, and claims administration system, encounter data from subcontractors Magellan Behavioral Health and VSP.

    e. Pharmacy data: data received from the Health Plan's Pharmacy Benefit Management (PBM) vendor, and/or data feeds from DHCS delegated PBM vendor for Pharmacy carve out services.

    f. Laboratory data: lab test results in either EMR data or reported to plan by LabCorp and loaded to the Care Coordination Software System.

    g. Screening or assessment data: member surveys completed within the Care Coordination Software System.

    h. Clinical information on physical and/or behavioral health: medical records CPS and/or member reported information stored in the Care Coordination software system.

    i. Serious mental illness (SMI) and serious substance use disorder (SUD) data, as available.

    j. Data related to social determinants of health (SDOH): SDOH survey, Health Risk Assessment (HRA), or EMR data.

    k. Results from available Adverse Childhood Experience (ACE) screening: EMR data

    l. Other cross-sector data and information, including but not limited to housing, social services, ACE, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System {HMIS})

3. The National Director of Care Coordination, ECM RN or designee reviews potential ECM members through bi-weekly data analysis or by the incident report. New or refreshed data sources described above are received at varying intervals (daily, weekly, monthly). Data received is loaded into the Care Coordination Software Management system and the Health Plan's enrollment, provider, and claims administration system at varying intervals (daily or weekly). Based on data refreshes, reporting modules are refreshed daily.

Proactive Member Identification

1. At the direction of the National Director of Care Coordination, ECM RN Care Manager or designee, an information technology (IT) analyst creates and maintains reports, visualizations, and dashboards within the care management and utilization review system analytics platform and/or Business Intelligence (BI) reports to identify members who may qualify for ECM.

2. Reports and dashboards are reviewed by the National Director of Care Coordination, ECM RN Care Manager or designee. Members qualifying in whole or part for ECM services are enrolled into an ECM program within the Care Coordination software system when they are contacted and consent to enrollment in the program.

3. The National Director of Care Coordination, ECM RN Care Manager or designee identifies members by considering members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and Long-Term Services and Support (LTSS) needs.

4. The ECM RN and/or Community Health Worker conduct outreach to potential ECM enrollees identified using the ECM screening tool and Health Risk Assessment.

Requests for ECM Enrollment

1. The National Director of Care Coordination, ECM RN Care Manager or designee accepts requests via verbal referral, email, text, telephone for ECM services from Members and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s), ECM Providers, Other Providers and community-based entities, including those contracted to provide ILOS services.

    a. The ECM RN Care Manager or designee automatically authorizes Member initiated requests received directly from the enrollee, family or AR for newly enrolled Plan Members who were receiving ECM through their previous Medi-Cal managed care plan.

        i. The ECM RN Care Manager or designee makes a good faith effort to request records from the prior managed care plan once the member has initiated the ECM enrollment request.

        ii. The ECM RN Care Manager or designee utilizes the data from the DHCS Plan Data Feed to review the historical utilization data using a ninety (90) day look-back period to identify enrollees who have received ECM.

        iii. The ECM RN Care Manager or designee begins attempts to contact the enrollee within one (1) business day. Upon contact with the member, the ECM RN Care Manager or designee conducts a reassessment within five (5) business days.

2. Requests for ECM enrollment are submitted to the Health Plan by phone, fax, portal, email or mail. Requests are routed to the ECM RN Care Manager or designee for processing.

3. Once the request is received by the ECM RN Care Manager or designee, an authorization number is assigned through the Health Plan's Care Coordination software.

4. The ECM RN Care Manager or designee confirms that enrollees are not enrolled into any of the excluded programs, such as 1915 Waivers, Family Mosaic Project, California Community Transitions (CCT) Money Follows the Person (MFTP), outside Basic or Complex Case Management, or fully integrated programs for members dually eligible for Medicare and Medicaid (Cal Mediconnect, Fully Integrated Dual Eligible Special Needs Plans [FIDE-SNPs], Program for All-Inclusive Care for the Elderly [PACE])

5. The Health Plan's Utilization Department RN works in collaboration with the ECM RN Care Manager to collect documentation and review cases to confirm if a Member meets one or more of the Population of Focus criteria.

6. Requests that do not meet ECM enrollment criteria are submitted to the Health Plan's Medical Director for final determination.

7. Decisions and notifications are made by the UM RN or designee based on the type of request (Urgent Pre-Service, Non-Urgent Pre-Service) and are detailed in the guidelines set forth in Attachment A "Utilization Management Timeliness Standards"

8. The Health Plan's Utilization Review RN or designee does not pend requests for reasons other than missing documentation. Referral and authorization requests, if pended for missing data, are subject to the Utilization Management Timeliness Standards contained in Utilization Management Policy and Procedure, PHC California Authorization Referral Process.

9. Notification to Members is completed by telephone and in writing. Notification to Providers is completed in writing via fax, within the time frames specified in the Utilization Management Policy and Procedure, PHC California Authorization Referral Process. Adverse determinations require written notification per guidelines on adverse determinations.

Adverse Determinations

1. Only a physician holding an active, unencumbered state license may render an adverse determination regarding a service. The physician supplies the documented reasons for the adverse determination for the written notifications. The physician review is documented in the UM EHR system and designated to the Plan's Medical Director.

2. Plan Utilization Review: TRN submits to the treating provider and the member written notification of the adverse determination within two (2) working days after the member or provider is notified verbally of the adverse determination.

3. The written notification will include the utilization review criteria, medical necessity criteria, or plan benefits provision(s) used in the adverse determination, along with the source of such criteria.

4. Written notification will include the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process

5. The member may appeal orally or in writing through the Member Services Department.

Provider Education

1. The Health Plan's provider education program is outlined in PHC California Policy and Procedure PR 3, Provider Education and Training.

Definitions:

1. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination or services and comprehensive care management that is community-based, interdisciplinary, high-tough, and person-centered. ECM is a Medi-Cal benefit.

2. ECM Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

Monitoring:

The Director of Care Coordination or designee reviews, updates, and seeks approval from the Utilization Management Committee as needed, but at minimum annually.

Quality Improvement and Health Equity Committee (QIHEC)

Utilization Management to submit reports of UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications, as well as timeliness reports of referrals and authorizations to the appropriate QIS to be reviewed on a quarterly basis.

Reference(s):

1. See PHC-CA Authorization Referral Process

2. DHCS Contract 23-30211, Exhibit A, Attachment III, 2.3.3 Review of Utilization Data and 4.4.6 Member Identification for ECM

3. CalAIM ECM Policy Guide published August 2024

4. CalAIM ECM Referral Standards and Form Templates published August 2024

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
12/8/2023	18.4	Department of Health Care Services (DHCS)	Operational Readiness R.0072	Approved

Enhanced Care Management (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 form 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.

ECM referrals should be submitted to the Member's Managed Care Plan by **faxing** completed form to **Utilization Management Department at (888) 272-7656.**

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

Medi-Cal Member Information			
Date Referred:		Type of Referral:	Routine Expedited
Member ID:		Member Primary Phone Number:	
Member Name:		Member Date of Birth:	

Referral Source Information			
Referring Organization Name:		Referring Individual Name:	
Referring Individual Phone Number:		Referring Individual Emal:	
Referring Indiviual Relationship:		Referring Individual Title:	

Adult Member ECM Eligibility (age 21 or older)

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 elements that do not apply to the extent of your knowledge.** Please use the free text area to note any areas where further MCP review may be warranted.

Adults Experiencing Homelessness

POF Eligibility Indicator: If A = yes and B = yes, Member is eligible

Element	Yes or Blank
A. Member is experiencing Homelessness (unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence).	
B. Member has at least one complex physical, behavioral, or developmental health need (includes pregnancy or postpartum, 12 months from delivery), for which the Member would benefit from care coordination.	

Adults at Risk for Avoidable Hospital or ED Utilization

POF Indicator: [At least one of A, B, or C] = yes, Member is eligible.

Element	Yes or Blank
A. Over the last six months, the Member has had 5 or more emergency room visits that could have been avoided with appropriate care.	
B. Over the last six months, the Member has had 3 or more unplanned hospital and/or short-term skilled nursing facility stays that could have been avoided with appropriate care.	

Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs

POF Eligibility Indicator: [At least one factor in A] and B and [at least one factor in C] = yes, Member is eligible.

Element	Yes or Blank
A. Member meets eligibility criteria for, and/or is obtaining services through:	
A1. Specialty Mental Health Services (SMHS) delivered by MHPs: Significant impairment (distress, disability, or dysfunction in social, occupational, or other important activities) OR A reas onable probability of significant deterioration in an important area of life functioning.	

A2. Drug Medi-Cal Organization Delivery System (DMCODS): Have at least one diagnosis for Substance-Related and Addictive Disorder with the exception of Tobaccorelated disorders and non-substance-related disorders.	
A3. 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.	
B. 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; high measure (four or more) of ACEs based on screening; former foster youth; or history of recent contacts with law enforcement related to mental health or substance use symptoms.	
C. Member meets one or more of the following criteria:	
C1. High risk for institutionalization, overdose, and/or suicide	
C2. Use crisis services, ERs, Urgent Care, or inpatient stays as the primary source of care	
C3. 2+ ER visits due to serious mental health or SUD in the past 12 months	
C4. 2+ hospitalizations due to serious mental or SUD in the past 12 months	
C5. Pregnant or post-partum (up to 12 months from delivery)	

Adults Transitioning from Incarceration within the past 12 months

POF Eligibility Indicator: If A = yes and [at least one factor in B] = yes, Member is eligible.

Element	Yes or Blank
A. 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.	
B. Member has a diagnosis of:	
B1. Mental Illness	
B2. Substance Use Disorder (SUD)	
B3. Chronic Condition/Significant Non-Chronic Clinical Condition	
B4. Intellectual or Developmental Disability (I/DD)	
B5. Traumatic Brain Injury	
B6. HIV/AIDS	
B7. Pregnant or Postpartum (up to 12 months from delivery)	

Adults living in the community who are at risk for LTC Institutionalization POF Eligibility Indicator: If [At least one factor in A] and B and C = yes, Member is eligible.	
Element	Yes or Blank
A. Member meets at least one of the following criteria:	
A1. Living in the community and meets Skilled Nursing Facility (SNF) Level of Care criteria	
A2. 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	
B. 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)	
C. Member is able to reside continuously in the community with wraparound supports.	

Adult Nursing Facility Residents Transitioning to the Community POF Indicator: A and B and C = yes, Member is eligible.	
Element	Yes or Blank
A. Member is a nursing facility resident who is interested in moving out of the institution	
B. Member is a likely candidate to move out of the institution successfully	
C. Member is able to reside continuously in the community.	

Adult Birth Equity POF Indicator: A and B = yes, Member is eligible.	
Element	Yes or Blank
A. Member is pregnant or postpartum (through 12 months period)	
B. 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 meet this criteria (referring individuals should prioritize Member selfidentification).	

Enrollment in Other Programs or Services

Please use the **optional** table below to indicate other programs and services that the Member is receiving under Medi-Cal. Some Med-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 determinatin 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 "Additional Information" section at end of form.

Please leave blank all elements that do not apply to the extent of your knowledge.

Member Enrollment in Other Medi-Cal Programs or Services

Program or Service	Yes, No, Unsure
A. Dual Eligible Special Needs Plan (D-SNP)	
B. Hospice	
C. Fully Integrated Special Needs Plan (FIDE-SNP)	
D. Program for All Inclusive Care for the Elderly (PACE)	
E. Multipurpose Senior Services Program (MSSP)	
F. Assisted Living Waiver (ALW)	
G. Self Determination Program for Individuals with I/DD	
H. Home and Community-Based Alternatives (HCBA) Waiver	
I. California Community Transitions (CCT)	
J. HIV/AIDS Waiver	

Additional Information

Please use this section to provide additional comments, as needed. This section is optional.