

## Enhanced Care Management Benefit Referral Form –Child and Youth

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Enhanced Care Management (ECM) is a Medi-Cal benefit available to eligible members with complex needs. This form is used to collect information about the member to confirm eligibility. An ECM provider will be assigned to an eligible member who supports the member's population(s) of focus (POF).

To receive ECM, members must meet the Department of Health Care Services (DHCS) eligibility criteria for at least one of the POF described in the form. Members can be eligible for more than one POF, so please complete information for all applicable POFs for a member's age group.

Please submit ECM referrals by:

- Website: <https://providers.anthem.com/ca>
- Secure fax: **877-734-1854**
- Email: [CalAIMreferrals@anthem.com](mailto:CalAIMreferrals@anthem.com)
- Phone: at **800-407-4627** (TTY 711) outside L.A. County or **888-285-7801** (TTY 711) inside L.A. County and request CalAIM or ECM.

Per DHCS policy, we may not require any additional documentation (for example, supplemental checklists, ICD-10-CM codes, or *Treatment Authorization Request* forms) to authorize ECM.

Please complete sections 1 to 6. If there is a required section that you are unable to complete, please contact Anthem above for additional support prior to submission.

### 1. Member information – Asterisk (\*) indicates required information.

Date of referral*	
Type of referral*	<input type="checkbox"/> Routine <input type="checkbox"/> Expedited <i>Expedited Requests: Is use in instances where a provider indicates, or the MCP determines, that the standard request timeframe may seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function in accordance with APL 21-011.</i>
Member's managed care plan (MCO)*	
Member first name*	
Member last name*	

Member Medi-Cal client index number (CIN)	
MCO member ID number	
Member date of birth (MM/DD/YYYY) *	
Member primary phone number*	
Member preferred language	
Member PCP name	
Member residential address	<input type="checkbox"/> Please mark 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, if applicable	<input type="checkbox"/> Phone <input type="checkbox"/> Email
Parent/guardian/caregiver name, if applicable	
Parent/guardian/caregiver phone number, if applicable	
Parent/guardian/caregiver email, if applicable	

## 2. Referral source information

Referral organization name*	
Referral organization national provider identifier (NPI)	
Referring individual name*	
Referring individual title	
Referring individual phone number*	
Referring individual email*	
Referring individual relationship to member*	<input type="checkbox"/> Medical provider <input type="checkbox"/> Social service provider <input type="checkbox"/> Other: <b>please provide additional detail in Section 5 – Additional Comments.</b>
Community partners (non-ECM) ONLY	<p>Does the member have a preferred ECM provider? Please select one of the following:</p> <p><input type="checkbox"/> Yes, this member has a preferred ECM provider. Preferred ECM care manager: _____</p> <p>Preferred ECM provider organization: _____</p> <p><input type="checkbox"/> No, this member does not have a preferred ECM provider.</p>

ECM provider ONLY	<p>Does the referring organization recommend that the member be assigned to it as their ECM provider? Please select one of the following:</p> <p><input type="checkbox"/> Yes, our organization should be the member's ECM provider</p> <p><input type="checkbox"/> No, our organization recommends this member is assigned to a different ECM provider based on their needs.</p> <p><b>Please provide additional detail in Section 5 – Additional Comments.</b></p> <p><input type="checkbox"/> No, this member wants an alternative preferred ECM provider</p> <p>Preferred ECM care manager: _____</p> <p>Preferred ECM provider organization: _____</p>
ECM providers with presumptive authorization ONLY	<p>Has the member already started ECM services? Please select one of the following:</p> <p><input type="checkbox"/> Yes, this member has already started ECM services ECM benefit start date (MM/DD/YYYY): _____</p> <p><input type="checkbox"/> No, this member has not started ECM services. <i>ECM benefit start date is the date when billable ECM services were first provided to the member. This does not include outreach services.</i></p>

### 3. Member ECM eligibility by POF

Children and youth under 21 ECM eligibility or homeless families; mark all that apply.

If the member being referred is a child, youth, or family (homelessness), please review each indicator and indicate **yes** to all those that apply across the child and youth POF definitions, to help us determine whether the individual qualifies for ECM and to fully understand their needs. Leave indicators that do not apply blank. If you are referring a child or youth who is experiencing homelessness, and their family members or caretakers are also experiencing homelessness and have coverage through Medi-Cal, please consider referring all family members or caregivers for ECM services. MCPs are encouraged to work 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 Anthem.

☐ **Homelessness: homeless families or unaccompanied children or youth experiencing homelessness**

*Please confirm the Member meets at least one of the following criteria:*

☐ Child, youth, or family with members under 21 years old, who is experiencing homelessness (unhoused, in a shelter, losing housing in the 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 (for example, 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 (ED) utilization: children and youth at risk for avoidable hospital or ED utilization**

*Please confirm the member meets at least one of the following criteria in the last 12 months:*

☐ Child or youth has three or more ED visits that could have been avoided with appropriate care within the last 12 months;

AND/OR

☐ Child or youth had two 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.

OR

☐ Is at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet the numerical threshold specified above. Please provide additional detail in *Section 5 – Additional Comments*.

☐ **Serious mental health or substance use disorder (SUD): 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): members under age 21 qualify to receive all medically necessary SMHS services.

☐ Medi-Cal's drug delivery system (DMH-ODS): members under age 21 qualify to receive all medically necessary DMC-ODS services.

☐ Medi-Cal's drug (DMC) program: covered services provided under DMC shall include all medically necessary SUD services for individuals under 21 years of age.

☐ **Justice involved: children and youth transitioning from a youth correctional facility**

*Please confirm the member meets the following criteria:*

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

☐ **California Children's Services (CCS) or CCS whole child model (CCS WCM): children or youth enrolled in CCS or CCS WCM with additional needs beyond the CCS condition**

*Please confirm the member meets all 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, recent contacts with law enforcement, or crisis intervention services related to mental health, former foster youth, and/or SUD symptoms.

☐ **Foster care: children and youth involved in child welfare**

*Please confirm the member meets at least one 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.

☐ **Birth equity: pregnant and postpartum Individuals at risk for adverse perinatal outcomes**

*Please confirm the member meets all 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**

Please use the optional table below to indicate other programs and services that the member is receiving under Medi-Cal. Some services may require coordination with ECM. Because other services may offer support similar to ECM, members may be excluded from receiving ECM and these services at the same time. Anthem will review the information below and make a determination on the member’s eligibility for ECM. Anthem is responsible for determining ECM eligibility, not the referring individual.

To the extent known to the referring individual, If the member is enrolled in any other care management or coordination program(s) that require coordination with ECM (such as CCS or targeted care management within SMHS) please share additional information in *Section 5 – Additional Comments*. Leave blank all elements that do not apply to the extent of your knowledge.

Programs	
<input type="checkbox"/> Dual Eligible Special Needs Plan (D-SNP)	<input type="checkbox"/> Hospice
<input type="checkbox"/> Fully Integrated Special Needs Plans (FIDE – SNPs)	<input type="checkbox"/> Program For All Inclusive Care for the Elderly (PACE)
<input type="checkbox"/> Multipurpose Senior Services Program (MSSP)	<input type="checkbox"/> Self-Determination Program for Individuals for Individuals with I/DD
<input type="checkbox"/> Assisted Living Waiver (ALW)	<input type="checkbox"/> California Community Transitions (CCT)
<input type="checkbox"/> Home and Community-Based Alternatives (HCBA) waiver	<input type="checkbox"/> HIV/AIDS waiver

**5. Additional comments**  
*Please use this section to provide additional comments on sections 1 to 4, as needed.*

**6. Submission information and 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 Anthem via the submission methods above. After submission, Anthem will make an ECM

authorization decision within five 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.