Important: New Changes for Enhanced Care Management (ECM) Starting Wednesday, January 1, 2025

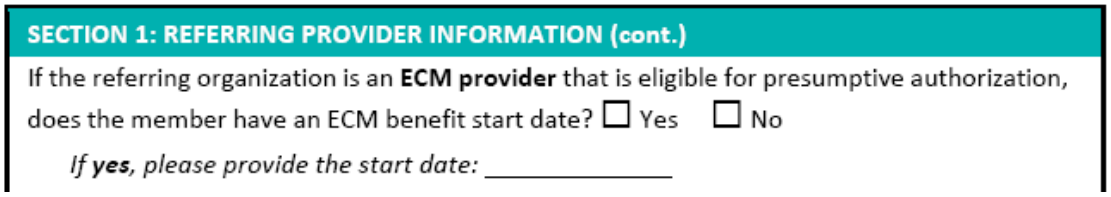
At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are sharing an important reminder with you.

The California Department of Health Care Services (DHCS) requires managed care plans to implement the following Enhanced Care Management (ECM) standardizations, effective Wednesday, January 1, 2025:

- Implement presumptive authorization.
- Provide a centralized location where authorization status can be viewed and checked.
- Update and implement standards for referrals, including updated referral templates.

To align with DHCS' requirements, the Alliance made the following changes:

1) **Referrals:** Updated the two (2) Alliance ECM – Approval Request Forms *(for Adults 21 Years of Age and Over)* and *(for Children/Youth Under the Age of 21)*. A copy of both forms are included with this communication. The forms are also available on our website at **www.alamedaalliance.org/providers/case-and-disease-management**.
2) **Presumptive Authorization:** The Alliance will provide presumptive authorization for up to 30 days of the ECM benefit start date for all contracted ECM providers serving any Population of Focus (PoF). Please ensure the appropriate field(s) on the Alliance ECM = Approval Request Form is completed to notify the Alliance to presumptively authorize services, including the **ECM benefit start date**.


SECTION 1: REFERRING PROVIDER INFORMATION (cont.)

If the referring organization is an **ECM provider** that is eligible for presumptive authorization, does the member have an ECM benefit start date? ☐ Yes ☐ No

*If **yes**, please provide the start date:* _____

Please Note: Even with presumptive authorization, ECM providers must submit the Alliance ECM – Approval Request Form with the appropriate supporting justification documentation as soon as possible and no later than five (5) working days before the end of the 30-day presumptive authorization period.

3) **Centralized Authorization:** To prevent duplication of services, we will be upgrading our Alliance Provider Portal and will display ECM authorization/enrollment status as part of the member's eligibility. This upgrade will be available in 2025 and will include information about ECM eligibility, outreach, and enrollment information. More information will be provided once available. To verify a member's ECM status, you may also call the Alliance ECM Department at **1.510.747.4546**.

We appreciate and thank you for the high quality care you provide your patients and your continued partnership in making a difference in our community.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Enhanced Care Management (ECM) – Approval Request Form
(for Adults 21 Years of Age and Over)

The Alameda Alliance for Health (Alliance) Enhanced Care Management (ECM) – Approval Request Form *(for Adults 21 Years of Age and Over)* is confidential. This form is for Alliance members **21 YEARS OF AGE AND OVER**.

If you believe that your patient may be appropriate for ECM services, please complete this form. Approvals are based on member eligibility.

INSTRUCTIONS

1. This form is for members **21 YEARS OF AGE AND OVER**.
2. If the member being referred is an adult, please review each indicator and select the box to **all** that apply across each Population of Focus (PoF). **Please leave blank any elements that do not apply to the extent of your knowledge.**
3. Please use **Section 5: Additional Comments** to provide any areas where further Alliance review may be warranted. For additional guidance on the ECM PoF definitions, please refer to the ECM Policy Guide at **www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf**.
4. Please print clearly, or type in all the fields below. Fields marked with * are required.
5. Attach a clinical summary and/or supporting documentation for ECM (e.g., clinic notes, hospital discharge summary, etc.).
6. Fax or send by secure email the completed form to the Alliance ECM Department at **1.510.995.3725** or **ECM@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

Date of Referral*: _____ Type of Referral*: _____

SECTION 1: REFERRING PROVIDER INFORMATION

Last Name*: _____ First Name*: _____

Title: _____ NPI Number: _____

Organization Name*: _____

Phone Number*: _____ Fax Number: _____

Email*: _____

Relationship to Member*: _____

SECTION 1: REFERRING PROVIDER INFORMATION (cont.)

If the referring organization is an **ECM provider** that is eligible for presumptive authorization, does the member have an ECM benefit start date? ☐ Yes ☐ No

*If **yes**, please provide the start date:* _____

If the referring organization is a **community partner**, does the member have a preferred ECM provider? ☐ Yes ☐ No

*If **yes**, please provide the ECM provider's full name:* _____

If the referring organization is an **ECM provider**, does the referring organization recommend that the member be assigned to it as their ECM provider? ☐ Yes ☐ No

SECTION 2: MEMBER INFORMATION

Last Name*: _____ First Name*: _____

Date Of Birth* (MM/DD/YYYY): _____

Alliance Member ID Number: _____ Client Index Number (CIN): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Primary Phone Number*: _____ ☐ Home ☐ Cell

Preferred Written Language: _____

Preferred Spoken Language: _____

PCP Full Name: _____

SECTION 3: MEMBER'S QUALIFYING CONDITION(S)

Please select all that apply, the member must meet all requirements in one (1) of the options to be eligible.

☐ **Option 1a – Adults without Dependent Children/Youth Living with them Experiencing Homelessness:** (Homeless families should complete the *ECM Approval Request Form (for Children/Youth Under the Age of 21)*)

Population of Focus (POF) Eligibility Indicator: If A = Yes AND B = Yes, member is eligible.

☐ **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 (1) 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.

☐ **Option 2 – Adults at Risk for Avoidable Hospital or Emergency Room Utilization:**

POF Eligibility Indicator: *At least one (1)* of A OR B = Member is eligible.

- ☐ **A.** Over the last 12 months, the member has had four (4) or more emergency room visits that could have been avoided with appropriate care.
- ☐ **B**. Over the last 12 months, the member has had two (2) or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays that could have been avoided with appropriate care.

☐ **Option 3 – Adults with Serious Mental Health and/or Substance Use Disorder:**

POF Eligibility Indicator: *At least one (1)* factor in A AND B AND *at least one (1)* factor in C = Member is eligible.

- ☐ **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 reasonable probability of significant deterioration in an important area of life functioning.
  - ☐ **A2.** Drug Medi-Cal Organization Delivery System (DMC-ODS): Have at least one (1) diagnosis for substance-related and addictive disorder with the exception of tobacco-related disorders and non-substance-related disorders.
  - ☐ **A3.** Drug Medi-Cal (DMC) Program: Have at least one (1) 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 (1) 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 (4) 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 (1) or more of the following criteria:
  - ☐ **C1.** High risk for institutionalization, overdose and/or suicide.
  - ☐ **C2.** Use crisis services, emergency rooms, urgent care, or inpatient stays as the primary source of care.
  - ☐ **C3.** Two (2) or more emergency room visits due to serious mental health or SUD in the past 12 months.
  - ☐ **C4.** Two (2) or more hospitalizations due to serious mental or SUD in the past 12 months.
  - ☐ **C5.** Pregnant or post-partum (up to 12 months from delivery).

☐ **Option 4 – Adults Transitioning from Incarceration:**

POF Eligibility Indicator: If A = Yes AND *at least one (1)* factor in B = Member is eligible.

- ☐ **A.** Member is transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or has transitioned from a correctional facility within the past 12 months.
- ☐ **B.** Member has a diagnosis of:
  - ☐ Mental illness
  - ☐ Substance Use Disorder (SUD)
  - ☐ Chronic Condition/Significant Non-Chronic Clinical Condition
  - ☐ Intellectual or Developmental Disability (I/DD)
  - ☐ Traumatic Brain Injury (TBI)
  - ☐ HIV/AIDS
  - ☐ Pregnancy or postpartum (up to 12 months from delivery)

☐ **Option 5 – Adults Living in the Community and At Risk for Long-Term Care Institutionalization:**

POF Eligibility Indicator: *At least one (1)* factor in A AND B AND C = Member is eligible.

- ☐ **A**. Member meets at least one (1) of the following criteria:
  - ☐ **A1.** Living in the community and meets the 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 (1) complex social or environmental factor influencing their health (including but not limited to, needing assistance with activities of daily living (ADLs), 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.

☐ **Option 6 – Adult Nursing Facility Residents Transitioning to the Community:**

POF Eligibility Indicator: A AND B AND C = Member is eligible.

- ☐ **A.** Member is in a nursing facility 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.

(Option 7 and Option 8 are for ECM children/youth only, and intentionally excluded in this form.)

☐ **Option 9 – Adults Who are Pregnant or Postpartum:**

POF Eligibility Indicator: A AND B = Member is eligible.

☐ **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 self-identification).

SECTION 4: OTHER MEDI-CAL PROGRAMS OR SERVICES

Other Medi-Cal programs or services that the member is enrolled in (please select all that apply):

☐ 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 Intellectual or Developmental Disability (I/DD)

☐ H. Home and Community-Based Alternatives (HCBA) Waiver

☐ I. California Community Transitions (CCT)

☐ J. Medi-Cal Waiver Program (MCWP) (formerly HIV/AIDS Waiver)

SECTION 5: ADDITIONAL COMMENTS (OPTIONAL)

Please use the space below to provide additional comments as needed:

Enhanced Care Management (ECM) – Approval Request Form
(for Children/Youth Under the Age of 21)

The Alameda Alliance for Health (Alliance) Enhanced Care Management (ECM) – Approval Request Form *(for Children/Youth Under the Age of 21)* is confidential. This form is for Alliance members who are **UNDER THE AGE OF 21**.

If you believe that your patient may be appropriate for ECM services, please complete this form. Approvals are based on member eligibility.

INSTRUCTIONS

1. This form is for members who are **UNDER THE AGE OF 21**.
2. If the member being referred is a child, youth, or family (experiencing homelessness), please review each indicator and select the box to **all** that apply across the child/youth Population of Focus (PoF). **Please leave blank any elements that do not apply, to the extent of your knowledge**.
3. Please use **Section 5: Additional Comments** to provide any areas where further Alliance review may be warranted. For additional guidance on the ECM PoF definitions, please refer to the ECM Policy Guide at **www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf**.
4. Please print clearly, or type in all the fields below. Fields marked with * are required.
5. Attach a clinical summary and/or supporting documentation for ECM (e.g., clinic notes, hospital discharge summary, etc.).
6. Fax or send by secure email the completed form to the Alliance ECM Department at **1.510.995.3725** or **ECM@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

Date of Referral*: _____ Type of Referral*: _____

SECTION 1: REFERRING PROVIDER INFORMATION

Last Name*: _____ First Name*: _____

Title: _____ NPI Number: _____

Organization Name*: _____

Phone Number*: _____ Fax Number: _____

Email*: _____

Relationship to Member*: _____

SECTION 1: REFERRING PROVIDER INFORMATION (cont.)

If the referring organization is an **ECM provider** that is eligible for presumptive authorization, does the member have an ECM benefit start date? ☐ Yes ☐ No

*If **yes**, please provide the start date:* _____

If the referring organization is a **community partner**, does the member have a preferred ECM provider? ☐ Yes ☐ No

*If **yes**, please provide the ECM provider's full name:* _____

If the referring organization is an **ECM provider**, does the referring organization recommend that the member be assigned to it as their ECM provider? ☐ Yes ☐ No

SECTION 2: MEMBER INFORMATION

Last Name*: _____ First Name*: _____

Date Of Birth* (MM/DD/YYYY): _____

Alliance Member ID Number: _____ Client Index Number (CIN): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Primary Phone Number*: _____ ☐ Home ☐ Cell

Preferred Written Language: _____

Preferred Spoken Language: _____

PCP Full Name: _____

Parent/Guardian/Caregiver Full Name (if applicable): _____

Parent/Guardian/Caregiver Phone Number (if applicable): _____

Parent/Guardian/Caregiver Email (if applicable): _____

Best Contact Method for Member/Caregiver: ☐ Phone ☐ Email

Best Contact Time for Member/Caregiver: _____

SECTION 3: MEMBER'S QUALIFYING CONDITION(S)

Please select all that apply, the member must meet all requirements in one (1) of the options to be eligible.

☐ **Option 1b – Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness:** 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 the Alliance, please consider referring all family members/caregivers for ECM services.

POF Eligibility Indicator: A OR B = Member/family is eligible.

- ☐ **A.** Child/youth or family with a member under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence).
- ☐ **B.** 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 shelters; or is abandoned in hospital (in a hospital without a safe place to be discharged to).

☐ **Option 2 – Children/Youth At Risk for Avoidable Hospital or ED Utilization:**

POF Eligibility Indicator: *At least one (1)* of A OR B = Member is eligible.

- ☐ **A.** Child/youth has three (3) or more emergency room visits that could have been avoided with appropriate care within the last 12 months.
- ☐ **B.** Child/youth has two (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.

☐ **Option 3 – Children/Youth with Serious Mental Health and/or Substance Use Disorder:**

POF Eligibility Indicator: *At least one (1)* factor in A = Member is eligible.

- ☐ **A.** Member meets eligibility criteria for, and/or is obtaining services through:
  - ☐ **A1.** Specialty Mental Health Services (SMHS) delivered by MHPs: Members under age 21 qualify to receive all medically necessary SMHS services.
  - ☐ **A2.** Drug Medi-Cal Organization Delivery System (DMC-ODS): Members under age 21 qualify to receive all medically necessary DMC-ODS services.
  - ☐ **A3.** Drug Medi-Cal (DMC) Program: Covered services provided under DMC shall include all medically necessary substance use disorder (SUD) services for individuals under 21 years of age.

☐ **Option 4 – Children/Youth Transitioning from a Youth Correction Facility:**

POF Eligibility Indicator: A only = Member is eligible.

☐ **A.** Member is transitioning from a youth correctional setting within the last 12 months.

(Option 5 and Option 6 are for ECM adults only, and intentionally excluded in this form.)

☐ **Option 7 – Children/Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition:**

POF Eligibility Indictor: A AND B = Member is eligible.

☐ **A.** Member is enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM).

☐ **B.** Member is experiencing at least one (1) 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 (4) or more) of Adverse Childhood Experiences (ACEs) screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.

☐ **Option 8 – Children/Youth Involved in Child Welfare:**

POF Eligibility Indicator: *At least one (1)* of A through E = Member is eligible.

☐ **A.** Member is under age 21 and is currently receiving foster care in California.

☐ **B.** Member is under age 21 and previously received foster care in California or another state within the last 12 months.

☐ **C.** 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.

☐ **D.** Member is under age 18 and eligible for and/or in California's Adoption Assistance Program.

☐ **E.** Member is under age 18 and is currently receiving or has received services from California's Family Maintenance program within the last 12 months.

☐ **Option 9 – Children/Youth who are Pregnant or Postpartum:**

POF Eligibility Indicator: A AND B = Member is eligible.

☐ **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, Alaska Native, and Pacific Islander members meet this criteria (referring individuals should prioritize member self-identification).

SECTION 4: OTHER MEDI-CAL PROGRAMS OR SERVICES

Other Medi-Cal programs or services that the member is enrolled in (please select all that apply):

- ☐ 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 Intellectual or Developmental Disability (I/DD)
- ☐ H. Home and Community-Based Alternatives (HCBA) Waiver
- ☐ I. California Community Transitions (CCT)
- ☐ J. Medi-Cal Waiver Program (MCWP) (formerly HIV/AIDS Waiver)

SECTION 5: ADDITIONAL COMMENTS (OPTIONAL)

Please use the space below to provide additional comments as needed: