



***Last Updated: October 2023, Version 2***

## **Intermediate Care Facility for the Developmentally Disabled Carve-In Frequently Asked Questions (FAQ)**

### **Introduction**

California Advancing and Innovating Medi-Cal, or CalAIM, is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM is also intended to make Medi-Cal a more consistent and seamless system. One goal of CalAIM is to support service coordination and comprehensive care planning for members residing in long-term care (LTC) facilities. All Medi-Cal members residing in LTC facilities will be enrolled in Medi-Cal managed care plans (MCPs), and those MCPs will cover and coordinate LTC in all counties in the State. MCPs can offer complete care coordination, care management, and provide a broader array of services, including CalAIM Enhanced Care Management and Community Supports for Medi-Cal beneficiaries, than the traditional Medi-Cal Fee-for-Service (FFS) system.

Effective January 1, 2024, all MCPs will become responsible for the full LTC benefit at the following facility types and homes<sup>1</sup>:

- Intermediate Care Facility for Developmentally Disabled (ICF/DD)
- ICF/DD-Habilitative (ICF/DD-H)
- ICF/DD-Nursing (ICF/DD-N)

This transition applies to the following counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba. The goal of the Medi-Cal LTC Carve-In is to provide better coordination across institutional and home and community-based settings as well as to make the LTC delivery system consistent across all counties in California. To support this transition, DHCS plans to offer webinars for MCPs and providers, as well as implementation

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<sup>1</sup> ICF/DD-Continuous Nursing Care Homes are not subject to the LTC Carve-in policy.



materials posted on the [Intermediate Care Facility for Developmentally Disabled \(ICF/DD\) Long Term Care Carve-In website](#).

This document addresses questions regarding the ICF/DD LTC Carve-In and will be updated regularly. Please submit questions about the ICF/DD LTC Carve-In to: [LTCtransition@dhcs.ca.gov](mailto:LTCtransition@dhcs.ca.gov).

Questions about CalAIM generally should be submitted to [CalAIM@dhcs.ca.gov](mailto:CalAIM@dhcs.ca.gov).

## ICF/DD LTC Carve-In Frequent Asked Questions (FAQ)

### Benefits

#### 1. Where can I find the transitioning counties for ICF/DD, ICF/DD-H, and ICF/DD-N Homes?

Please see the map and table provided below.

### Transitioning Counties for Intermediate Care Facilities: Developmentally Disabled

- County Organized Health Systems (COHS) Counties
- Counties Transitioning to Managed Care



<b>COHS Counties with LTC ICF/DD Services already covered in Medi-Cal Managed Care</b>	<b>Counties Carving-in LTC ICF/DD Services into Managed Care Effective January 1, 2024</b>
Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba

**2. (Updated October 2023) Which populations are subject to the ICF/DD Homes LTC Carve-In?**

The ICF/DD LTC Carve-In to managed care is determined by the ICF/DD Home Types individuals are residing in and their Medi-Cal eligibility status; Provider Type 17–LTC and claim type code 02, including billing accommodation codes.

**3. (Updated October 2023) Will Adult Residential Facility for Persons with Special Health Care Needs (Senate Bill [SB] 962 Homes) be included in the ICF/DD Carve-in?**

SB 962 Homes are not included in the January 1, 2024 ICF/DD LTC Carve-In. The January 1, 2024 ICF/DD LTC Carve-In applies only to the following types of Homes:

- ICF/DD
- ICF/DD-H
- ICF/DD-N

**4. (Updated October 2023) How will MCPs identify the ICF/DD members in their enrollment file?**

A special indicator for the LTC transitioned population will be reflected on the Weekly Plan File starting November 30, 2023. The special indicator name is "LTC\_2024". Plans should use the claims data provided by DHCS to determine the facility type that the member resides in (see Question 2).

## Payments and Billing

**5. (Updated October 2023) Will ICF/DD Homes still need to do cost reporting after January 1, 2024?**

Yes, ICF/DD Homes will still need to perform cost reports as they do today before the Carve-In. ICF/DD Homes will complete cost reports in the same way and submit the completed cost reports to the FFS Rates Development Division.

**6. (Updated October 2023) If an ICF/DD Home submits a claim for reimbursement through Medi-Cal FFS on or after December 31, 2023, will the claim be automatically denied?**

Yes, if a provider submits a claim to Medi-Cal FFS for ICF/DD services provided to members enrolled in an MCP after December 31, 2023, it will automatically be denied. The provider must submit claims or invoices to the MCP starting on January 1, 2024.

To minimize the delay in redirecting the claim/invoice, DHCS Clinical Assurance Division (CAD) has established processes for identifying ICF/DD Treatment Authorization Requests (TARs) submitted to FFS, rather than MCPs, after the January 1, 2024 transition. If CAD receives ICF/DD TARs for members enrolled in an MCP after January 1, 2024, CAD will deny the TAR and notify the MCP's Long-Term Services and Supports (LTSS) Liaison of the denial so they can work with the ICF/DD Home to submit the TAR to the MCP. CAD staff will continue to review TARs received after January 1, 2024 for FFS members. If MCPs have questions regarding the ICF/DD Home TARs, they may email: [CAD.ICF/DD@dhcs.ca.gov](mailto:CAD.ICF/DD@dhcs.ca.gov).

## Authorizations

**7. What is the expected turn-around time for routine authorizations, such as when member is transitioning from a Skilled Nursing Facility or from the community to an ICF/DD Home?**

In accordance with Health and Safety Code (H&S) section 1367.01, routine authorizations are subject to a turnaround time of five (5) days. Expedited authorization decisions for service requests occur when a Member's Provider indicates, or MCP, Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72-hours after receipt of the request for services in accordance with 42 CFR section 438.210(d).

## Complaint Resolution

### **8. How will complaint resolution be handled?**

All MCPs are required to maintain an appeals and grievances process that is accessible to Members and provide a Notice of Action (NOA) to members any time a requested service is denied, modified, or reduced.

All MCPs have an appeals and grievances process related to service authorization denials for which the MCP is responsible. See [All Plan Letter \(APL\) 21-011](#).

## Continuity Of Care

### **9. (Updated October 2023) Will DHCS provide the MCPs with a list of approved TARs for new members in advance of the January 1, 2024 transition?**

Yes, the data to be provided to MCPs in November 2023 will include FFS TARs approved by DHCS for the transitioning population. The file layout is similar to the Seniors and Persons with Disabilities TAR Detail File currently sent monthly to MCPs from DHCS. ICF/DD Homes are also encouraged, but not required, to send a copy of TARs to the MCPs prior to the January 1, 2024, transition to ensure the MCPs have the current authorization information.

Post January 1, 2024 implementation, MCPs will receive TAR and Plan Data Feed data for members new to their MCP or transitioning between MCPs on a monthly basis. The Plan Data Feed provides 12 months of historical utilization data to the MCPs on a monthly basis. Data includes paid pharmacy, dental, specialty mental health, FFS medical claims, and encounters from other MCPs.

### **10. (Updated October 2023) When should ICF/DD residents begin to make their MCP selections?**

ICF/DD Homes are encouraged to work with their residents and authorized representatives as appropriate to make their plan selections as soon as they receive their Medi-Cal choice packet in November 2023. Once plan selections are made, ICF/DD Homes are encouraged to promptly communicate and provide the individuals' authorizations to the appropriate MCP. While DHCS will be providing all MCPs with authorizations data for current ICF/DD Home residents as part of a data exchange prior to January 1, 2024, further coordination between the Homes and MCPs may be helpful to ensure a seamless transition.

## Member Notices and Communications

**11. (Updated October 2023) Will the one-page ICF/DD Member Transition Fact Sheet — "How does it affect me?" — be mailed?**

The ICF/DD Member Transition (Plain Language) Fact Sheet is posted on [the DHCS ICF/DD LTC Carve-In Member Information webpage](#), but will not be mailed out. DHCS developed the Fact Sheet with the ICF/DD Workgroup's and consumer advocacy groups' feedback to describe the member's continuity of care rights in plain terms.

**12. (Updated October 2023) When will DHCS send the 60-day and 30-Day Letter to ICF/DD Residents about the transition?**

DHCS will mail the 60-day Member Notice to ICF/DD, ICF/DD-H, and ICF/DD-N residents and their authorized representatives to be received no later than November 1, 2023 and the 30-day Member Notice no later than December 1, 2023.

**13. (Updated October 2023) When do ICF/DD Residents need to enroll into a Medi-Cal Managed Care Plan before DHCS assigns them into a Plan?**

When a member has more than one plan option, the member will need to choose a plan by the date listed in their "My Medi-Cal Choice Packet", which will be mailed to eligible members beginning November 3, 2023, or they will be automatically enrolled in a plan. Additionally, members will receive Enrollment Notices 60 days and 30 days before January 1, 2024, which will include the plan they will be enrolled in if they do not choose one by the date listed in their "My Medi-Cal Choice Packet".

**14. (Updated October 2023) How often may an ICF/DD Resident change their Managed Care Plan?**

If a Medi-Cal managed care member has a choice of more than one plan option, they may change their plan enrollment on a monthly basis by calling Health Care Options at 1 (800) 430-4263. Medi-Cal managed care members in County Organized Health Systems/Single Plan counties where Kaiser Permanente is available may switch plans if certain Kaiser Permanente enrollment criteria is met. Duals who reside in counties that are part of the Medi-Cal matching plan policy will automatically be enrolled in a MCP that matches their Medicare Advantage plan. For more information about Health Care Options, please visit [the Medi-Cal Managed Care Health Care Options \(HCO\) website](#).

**15. (Updated October 2023) How can an individual update their authorized representative?**

If a member needs to have a Representative added to their case and the member is a Social Security beneficiary, they must reach out to their local Social

Security office to add their Authorized Representative. If the member is not a Social Security beneficiary, they must reach out to their local county office to add/update the individual or organization appointed their Authorized Representative. In some cases due to system limitations, individuals appointed as Authorized Representative through their local county office may not be reflected in Medi-Cal Eligibility Data System (MEDS). Notices will be posted online and links to the notices will be provided to the facilities so that they can access them as well. All members and their Authorized Representatives will be able to access the notices located online.

**16. (Updated October 2023) Will the member's Authorized Representative also receive the member notice?**

The 60-day and 30-day notices will be mailed to the address indicated for the member in the MEDS. The notices will also be mailed to the member's Authorized Representative as reflected in MEDS.

### **Contracts**

**17. (Updated October 2023) If an ICF/DD Resident is enrolled into a Plan that is not under contract with the ICF/DD Home, will the ICF/DD Home still be paid by that Plan under continuity of care?**

If a resident in an ICF/DD Home is enrolled into a MCP that does not have an existing contract with their ICF/DD Home, the member will automatically have access to 12 months of continuity of care during which the MCP will pay Homes the ICF/DD Home payment rates while the MCP works to bring the Home into its network. Please see [APL 23-022](#) for further information.

**18. (Updated October 2023) What are the MCPs by county who will be contracted with DHCS in 2024?**

The list of MCPs by county effective January 1, 2024 can be found at: [Medi-Cal Managed Care Plans by County](#).

**19. (Updated October 2023) Will an ICF/DD Home that has not completed credentialing on January 1, 2024, still be able to be reimbursed by the MCP?**

Yes, an ICF/DD Home will still be able to be reimbursed beginning January 1, 2024, while undergoing credentialing as long as the ICF/DD Home submits the required initial documentation prior to January 1, 2024. The required initial documentation consists of a W-9 Request for Taxpayer Identification Number and Certification, an MCP Ancillary Facility Network Provider Application, Certificates of Insurance (Professional and General Liability), a City or County Business License (excluding ICF/DD-H and -N Homes with six [6] or less residents), Ownership Disclosure, and an Attestation that aligns with the

Attestation language provided in the attachment to APL 23-023. This initial documentation provides MCPs with the relevant business information they need to create the claims payment profile for an ICF/DD Home.

### **Share of Costs**

**20. (Updated October 2023) Who is responsible for collecting the member's system of care?**

The ICF/DD Homes will be responsible for collecting the member's system of care which must then be reported by the ICF/DD Homes when they submit claims to the MCPs. Refer to the Billing and Invoicing Guidance for details to be included on claims.

### **LTSS Liaison**

**21. What is the expected role of the LTSS liaison? Depending on MCP operations, will there be different plan staff responsible for claims troubleshooting versus care transitions?**

MCPs must identify an individual, or set of individuals, (either MCP or Subcontractor staff) to serve as liaisons for the LTSS Provider community. The LTSS liaison is not required to be credentialed/licensed but must have the ability to support the ICF/DD population's service needs. These staff must be trained by the MCP to identify and understand the full spectrum of Medi-Cal LTC, including payment and coverage rules. LTSS liaisons must serve as a single point of contact for service providers in a Provider representative role. LTSS liaisons may also work with transitional care services staff to support care transitions, as needed. LTSS liaisons must assist service providers in addressing claims and payment inquiries in a responsive manner and assist with care transitions among the LTSS Provider community to best support a Member's needs. LTSS liaisons do not have to be a clinical licensed professional but may be fulfilled with a non-licensed or paraprofessional. Once MCPs have identified their LTSS liaisons, MCPs must disseminate their contact information to their Network Providers. MCPs must also notify Network Providers of changes to contracted MCPs LTSS liaison assignment expeditiously in order to ensure coordination and services offered to Members.

**22. Are Letters of Authorization and Bed Hold orders required to be signed by a Physician?**

Only bed hold orders will be required to be signed by a physician.

**23. (Updated October 2023) Can the approval letter issued by the MCP count as the bed hold approval notification in lieu of the ICF/DD Home issuing a second approval?**

The ICF/DD Home does not need to issue an approval letter if the MCP has issued an approval letter.

### **Surveys and Inspection Findings**

#### **24. Where are the Surveys and Inspection Findings posted for California Department of Public Health (CDPH) reviews of ICF/DD Homes?**

The survey findings are posted on the CDPH website at the link below. Results can be found for each facility reviewed in a search by the individual facility.

CDPH California Health Facilities Information Database:

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx>

### **Medical Necessity**

#### **25. Does the Regional Center's determination of Medical Necessity also stand for reauthorization?**

Yes, the Regional Center's determination of Medical Necessity stands for both initial authorizations and reauthorizations.

#### **26. What documentation will the MCP use to determine Medical Necessity?**

Medical Necessity is determined by the Regional Center using documentation reflecting current care needs and the member's prognosis. ICF/DD Homes will send the HS231, DHCS 6013A, and MCP ICF/DD Authorization Request Form to the MCP as proof of Medical Necessity. ICF/DD-N Homes will send an Individual Service Plan with re-authorizations. If documentation is lacking, the MCP can request additional supporting documents to substantiate medical necessity.

#### **27. MCPs may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered. Does this also include vitamins and supplements? Are these drugs the J-codes that are administered by licensed healthcare providers? Are MCPs required to cover every drug billed on an institutional claim or is it at the MCP's discretion to choose to cover only a select group of drugs and other therapies otherwise covered/not covered?**

MCPs must also allow Members to maintain current drug therapy, including non-formulary drugs, until the Member is evaluated or re-evaluated by a Network Provider. The claim type determines the financial responsibility for prescription drugs. Drugs dispensed by a pharmacy and billed on a pharmacy claim are carved out of the MCP Contract and will continue to be covered by Medi-Cal Rx; there will be no changes for these outpatient prescription drug benefits. However, in cases where drugs are furnished by a Provider (i.e., in a doctor's office or other clinical setting) and billed on a medical or institutional claim, the MCP is responsible. MCPs may choose to cover drugs not covered by Medi-Cal Rx,

inclusive of over-the-counter drugs and other therapies otherwise not covered by Medi-Cal.

## Dental

### **28. (Updated October 2023) How will this transition affect dental care for members?**

The ICF/DD carve-in to managed care will not affect how dental care is provided to members. Members will continue to receive the same dental services from the same delivery system as they do today, either through FFS or Dental Managed Care in the following counties: Sacramento and Los Angeles.

## Oversight and Quality Assurance

### **29. What type of oversight are Regional Centers currently conducting? How does Regional Center oversight differ from MCP oversight?**

Regional Centers monitor consumers' service delivery in accordance with [Title 17 § 56103](#). This includes a quarterly meeting with the consumer to review progress toward achieving Incentive Payment Program objectives and may include review of records and accounts of the consumer's cash resources, personal property, and valuables. If the Regional Center representative finds any evidence of suspected licensing violations during a review, they must report such violations immediately to the appropriate CDPH Licensing and Certification district office.

## Regional Centers

### **30. Will Regional Centers have a Regional Center Directive, similar to APL 23-023?**

Yes, the Department of Developmental Services (DDS) will issue guidance to regional centers with details of the Carve-In. The guidance will be available on the DDS website.

### **31. Does a Regional Center still hold responsibility for case management/care coordination for members residing in an ICF/DD Home, or will this be defaulted to the role of MCPs?**

Yes, case management will continue to be a function of the Regional Center, including coordinating with the MCP for the provision of Early and Periodic Screening, Diagnostic, and Treatment for eligible populations. MCPs are required to coordinate and work with Regional Centers in the identification of services that will be provided to the Members by the MCP. The goal is to reduce any duplication of effort or work among the MCPs and Regional

Centers, and to ensure the plans are fully aware of the Members' needs and the services to be provided by the MCPs and Regional Centers.

**32. How will MCPs be informed about the designees for the Regional Center Director/Local Mental Health Director who may determine requests for services made on the Certification for Special Treatment Program Services (HS 231) form?**

Regional Center staff will be responsible for completing the HS 231 form certifying the level of care and sending to the ICF/DD Home. The ICF/DD Home submits the packet to the MCP. MCP staff should work with the Regional Center contact for any questions that may arise.

**33. Who is responsible for sending approval and denial Notice of Action letters?**

The MCP will be responsible for sending approval and denial notices for any actions taken by the MCPs.

**34. Is the idea that upon Regional Center Director/Local Mental Health Director determination, the Regional Center Director/Local Mental Health Director would forward their decision to the Managed Care Plan?**

No. The Regional Center will complete the HS 231 form to certify the level of care and send it to the ICF/DD Home. The ICF/DD Home will submit the form as part of the packet to the MCP.

**35. (Updated October 2023) Based on the Certification for Special Treatment Program Services (HS 231) form instructions, who is the designee of the Regional Center Director/Local Mental Health Director that will review requests for services and make final determinations?**

Part I of the HS 231 form must be completed by the ICF/DD home staff. Part II of the form must be completed by either the Regional Center Director or the Local Mental Health Director of the ICF/DD home.

**36. (Updated October 2023) Is the Regional Center Director/Local Mental Health Director responsible for sending approval and denial notice of actions letters?**

No, the MCPs are responsible for sending the approvals/denial NOA letters. However, it is the responsibility of either the Regional Center Director or the Local Mental Health Director of the ICF/DD Home to authorize the approval or deny the request for services.

**37. Is the new policy of procedures for the Regional Center Director/Local Mental Health Director determination that the Regional Center**

**Director/Local Mental Health Director would forward this decision to the Managed Care Plan?**

No, staff of the ICF/DD Home are responsible for sending the approvals/denial NOA letters to the MCPs. However, it is the responsibility of either the Regional Center Director or the Local Mental Health Director of the ICF/DD Home to authorize the approval or deny the request for services.

**Documentation**

**38. (Updated October 2023) Can Managed Care Plans develop their own forms or are MCPs only to use the HS 231 and DHCS 6013 A?**

MCPs are to utilize the HS 231 and the DHCS 6013 A ([Medical Review/Prolonged Care Assessment](#)) form or the information found on the DHCS 6013 form in any format (e.g., a copy of the Incentive Payment Program or Individual Service Plan).

**39. (Updated October 2023) If the transitioning ICF/DD member is enrolled in the MCP on January 1, 2024, and the member is residing in an ICF/DD Home outside the MCP's service area, does the MCP request disenrollment?**

No, the MCP should not request disenrollment. The member's address drives the plan enrollment and will only need to be changed if it does not reflect the address of the ICF/DD home.

**Transportation**

**40. What Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) is provided by the MCP?**

Per APL 22-008, MCPs must provide round trip NMT services for members to obtain medically necessary Medi-Cal services, including those not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and other benefits through Medi-Cal FFS delivery system such as pharmacy services. At minimum, MCPs must provide NMT for members picking up drug prescriptions that cannot be mailed directly to the member, and for members picking up medical supplies, prosthetics, and other equipment. MCPs must not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and must provide the NMT service within timely access standards.

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender. MCPs are required to provide

medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT services are required for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. MCPs must also have processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

At minimum, MCPs must provide the lowest cost type of NEMT service that is adequate for the member's medical needs, as determined by the medical professional. MCPs must ensure that there are no limits to receiving NEMT as long as the member's services are medically necessary, and the member has prior authorization for the NEMT. For Medi-Cal services that are not covered under the MCP Contract, MCPs must make their best effort to refer and coordinate NEMT services. However, MCPs must provide medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx. For more information, please see [APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses](#).

## **Billing**

### **41. How do you document multiple diagnoses on an invoice submission when multiple diagnoses are billed?**

Up to 12 diagnoses can be reported in the header on the Form CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.

The reason for the service drives code sequencing. This is generally the first-listed diagnosis. Once the first-listed diagnosis is established, it may be followed by other coexisting conditions. If multiple medical problems were addressed and multiple diagnoses are needed to reflect the complexity of the care delivered, list the most important or serious condition the individual was treated for first. ICD 10 coding rules state you cannot use R/O, probable, suspected, possible, and so forth as diagnosis codes. More sourcing information can be found here: [Official ICD-10 Guidelines](#).