

DATE: June 10, 2026

ALL PLAN LETTER 26-012

SUPERSEDES ALL PLAN LETTER 24-011

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH
DEVELOPMENTAL DISABILITIES – LONG-TERM CARE BENEFIT UNDER
MANAGED CARE

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities^{1,2} services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative for Medi-Cal managed care Members.^{3,4} This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes

“Facility” and “Home” are interchangeable terms for an ICF/DD Facility and can include the following types: (1) ICF/DD-H as defined in Health and Safety Code (H&S) section

¹ Throughout this document, the term “developmentally disabled” is used to match current California Code of Regulations (CCR) language. The CCR is searchable at <https://govt.westlaw.com/calregs/Search/Index?Template=Find>. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as “people with intellectual and other developmental disabilities.”

² Welfare and Institutions Code (W&I) section 4512 defines developmental disability to be inclusive of intellectual disability and disabling conditions found to be closely related to intellectual disability or which require similar treatment. State law is searchable at: <https://leginfo.legislature.ca.gov/faces/home.xhtml>.

³ Further information about CalAIM can be found at: <https://www.dhcs.ca.gov/CalAIM>.

⁴ For more information on the CalAIM LTC Carve-In, see the CalAIM ICF/DD LTC Carve-In page on DHCS’ website at: <https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx>.



1250(e); (2) ICF/DD-N as defined in H&S section 1250(h); and (3) ICF/DD as defined in H&S section 1250(g).

Note: This does not include ICF/DD-Continuous Nursing Care Program.⁵

The ICF/DD Home living arrangement is a Medi-Cal covered service offered to individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system.⁶

This includes ICF/DD 60+ bed facilities, ICF/DD 1-59 bed facilities, ICF/DD-H 7-15 bed Homes, ICF/DD-H 4-6 bed Homes, ICF/DD-N 7-15 bed Homes, and ICF/DD-N 4-6 bed Homes. Throughout this document, the term ICF/DD Home is used to generally refer to these facilities and homes unless otherwise specified

BACKGROUND:

The Medi-Cal program provides services through both a Fee-For-Service (FFS) and managed care delivery system. While Medi-Cal managed care is available statewide, the covered benefits presently vary among counties depending on the county-specific MCP model.

CalAIM seeks to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility through benefit standardization. To further these goals, the Department of Health Care Services (DHCS) implemented benefit standardization – also termed a “carve-in” – of the ICF/DD Home benefit statewide.⁷

Prior to January 1, 2024, only County Organized Health System (COHS) MCPs covered ICF/DD benefits under the institutional LTC services benefit. Members receiving ICF/DD services in non-COHS counties were served through Medi-Cal FFS. Pursuant to Medi-Cal’s benefit standardization policy, effective January 1, 2024, Members who reside in an ICF/DD Home must be enrolled in an MCP.⁸

1. Member Rights Through the Lanterman Act⁹

⁵ See the CalAIM ICF/DD LTC Carve-In page on DHCS’ website, at: <https://www.dhcs.ca.gov/provgovpart/Pages/Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In.aspx>.

⁶ The Department of Developmental Services (DDS) provides a list of Regional Centers and contact information, available at: <https://www.dds.ca.gov/rc/listings/>.

⁷ See Attachment 1 of APL 21-015 for more detailed information on Mandatory Managed Care Enrollment. APLs and their associated attachments are searchable at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

⁸ Certain populations are exempted from mandatory managed care enrollment. Please see APL 21-015 for more information.

⁹ See the Lanterman Act and Related Laws, available at: https://www.dds.ca.gov/wp-content/uploads/2023/02/Lanterman_2023_Pub.pdf.

The Lanterman Developmental Disabilities Services Act (Lanterman Act) provides an entitlement to services and supports for individuals with intellectual and developmental disabilities and their families.¹⁰ It mandates comprehensive services and supports to enable people to live more independent, productive, and fulfilled lives. Regional Centers, as administered by DDS, are governed by the Lanterman Act.

The Lanterman Act outlines (1) The rights of individuals with developmental disabilities and their families, (2) How the Regional Centers and service Providers can assist these individuals, (3) What services and supports individuals and family members can obtain, (4) How to continuously engage with the Individualized Program Plan (IPP) to get needed services, as well as (5) Additional important information, including information regarding individual rights. California's Regional Center delivery system established under the Lanterman Act provides lifelong services and supports to assist those served to lead the most independent and productive lives in their chosen communities. There are 21 Regional Centers throughout the state.¹¹

Required functions of the Regional Center system include intake, assessment, eligibility determination, person-centered planning, case management, and the purchase of necessary services and supports for eligible individuals. Regional Centers develop, purchase, and coordinate the services in each person's IPP.

Individuals' service and support choices are a primary focus of person-centered planning under the Lanterman Act. Specifically, the Lanterman Act states:

Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Members of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, members and their families, when appropriate, should participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including

¹⁰ The Lanterman Act and Related Laws.

¹¹ DDS provides a list of Regional Centers and contact information, available at: <https://www.dds.ca.gov/rc/listings/>.

education, employment, and leisure, the pursuit of their own personal future, and program planning and implementation.¹²

Regional Centers develop an IPP for each individual with intellectual and/or developmental disabilities, based on the individual's person-centered goals and needs.¹³ An IPP serves as a contract between the Regional Center and an individual, and identifies (1) all services and supports the individual needs and is entitled to receive, and (2) whether the Regional Center will provide, supervise, or pay for the services, or another agency will. The IPP includes all services and supports the individual needs, even if a service will be provided by another source, such as Medi-Cal.¹⁴ The IPP process centers on the individual, and if appropriate, the individual's parents, legal guardian or conservator, or Authorized Representative. The individual may choose whomever they wish to take part in their IPP meeting. The IPP is an ongoing process that is updated regularly, and through the life cycle of the individual.

The Lanterman Act is very specific and detailed as to Regional Centers' responsibilities and the development and implementation of the IPP. The services identified in the individuals' IPPs go beyond those covered by Medi-Cal and MCPs. To the extent that MCPs provide some of the same or similar services to those provided by Regional Centers, the MCP services do not duplicate or supplant Regional Centers' duties under the Lanterman Act. Regional Centers are required to comply with the provisions of the Lanterman Act, regardless of whether similar services are also provided by MCPs.¹⁵

An Individual Service Plan (ISP) also is developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the individual, direct care staff, and should include all relevant staff of other agencies involved in serving the individual.¹⁶ The ISP implements the requirements of the Regional Center's IPP and is based on a detailed individual developmental assessment which includes disabilities, developmental strengths, and the individual's needs. It includes active treatment goals. The ISP is completed 30 days following a transition to an ICF/DD Home.

¹² See page 48 of the Lanterman Act and Related Laws, at: https://www.dds.ca.gov/wp-content/uploads/2023/02/Lanterman_2023_Pub.pdf.

¹³ W&I section 4646.

¹⁴ W&I section 4646.5.

¹⁵ A list of services commonly provided by Regional Centers can be found at: https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf.

¹⁶ Information on the Client Assessment can be found in 22 CCR section 76859.

2. Benefit Eligibility

To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the director of DDS, in consultation with the Superintendent of Public Instruction, this term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability but shall not include other handicapping conditions that are solely physical in nature.¹⁷

POLICY:

Effective January 1, 2024, DHCS will require Non-Dual and Dual LTC Members (including those with Medi-Cal Share of Cost (SOC) coverage) to enroll in an MCP and receive their LTC ICF/DD Home benefit through their MCP. Enrollment into an MCP does not change a Member's relationship with their Regional Center. Access to Regional Center services and to the current IPP process remains the same.

I. Benefits Requirements

1. ICF/DD Home Services Benefit Requirements

Effective January 1, 2024, MCPs must provide all Medically Necessary Covered Services for Members residing in or obtaining care in an ICF/DD Home, including home services, professional services, ancillary services, and transportation services. MCPs must also provide the appropriate level of Care Coordination, as outlined in this APL and in adherence to requirements in the MCP Contract and DHCS' Population Health Management (PHM) Policy Guide.¹⁸

MCPs in all counties must authorize and cover Medically Necessary ICF/DD Home services, consistent with definitions in the Medi-Cal Provider Manual.¹⁹ All MCPs must ensure Members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231.²⁰ MCPs must receive a copy of the

¹⁷ W&I section 4512(a).

¹⁸ See the PHM Policy Guide, available at: <https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf>.

¹⁹ See the Medi-Cal Provider Manual, at: <https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/publications/manual?community=long-term-care>.

²⁰ Form HS 231 is available at: https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/E3C0332D-4A0B-4366-96B6-AA734CC3205C/dhcs0231-certification-for-special-treatment-program-services.pdf?access_token=6UyVkkRRfByXTZEWIh8j8QaYyIPyP5ULO.

Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.

2. Included and Excluded Services for ICF/DD Homes

The list of services that are included and excluded from the ICF/DD, ICF/DD-H, and ICF/DD-N Homes' per diem are established in 22 CCR sections 76345 through 76355 (for ICF/DD-N); 22 CCR sections 76853 through 76906 (for ICF/DD-H); and 22 CCR sections 76301 through 76413 and 22 CCR section 51165 (for ICF/DD) and listed in Attachment A.

MCPs must coordinate benefits with Other Health Coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage. Such coordination of benefits must include recognizing OHC as the primary payer and the Medi-Cal program as the payer of last resort by exercising Cost Avoidance and conducting post-payment recovery for the reasonable value of the services if the OHC is identified retroactively, if the Member has an OHC indicator of A, or if the service is required to be "pay and chase."^{21, 22}

Members may still utilize their OHC after enrollment in the MCP. OHC providers do not have to be in the Member's MCP Network to continue providing services or billing the MCP for copays.²³

If a Member has both Medicare and Medi-Cal coverage, there will be no changes to the Member's Medicare coverage as a result of the ICF/DD Homes benefit standardization. For Members who are dually Medicare and Medi-Cal covered, or who have OHC, the MCP must coordinate care and address coverage needs, regardless of payer source.

Medicare does not cover LTC ICF/DD Home benefits. LTC ICF/DD Home benefits are exclusively covered by Medi-Cal. ICF/DD Homes are not enrolled in Medicare, and do not bill Medicare for LTC ICF/DD Home benefits they provide. Members may, however, receive other benefits from Medicare in addition to the ICF/DD Home benefits that fall to the MCP to coordinate.

MCPs must ensure that Network Providers have appropriate training on benefits coordination, including balanced billing prohibitions.

As of January 1, 2024, transportation services will be coordinated between the MCP and ICF/DD Home.

²¹ A "pay and chase" arrangement is when Medi-Cal pays for the Member's services and then seeks reimbursement from the Member's OHC.

²² The existence of OHC must not be a barrier to accessing ICF/DD services.

²³ More information on mandatory managed care and OHC is available at:

<https://www.dhcs.ca.gov/services/Documents/MCQMD/OHC-and-MMCE-Fact-Sheet.pdf>.

MCPs must provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services as set forth in the MCP Contract and APL 22-008 unless otherwise covered.²⁴

Day Program and related transportation (referenced in the ICF/DD State Plan Amendment (SPA)²⁵) must be provided by ICF/DD Homes and are not the responsibility of MCPs.

Consistent with guidance in APL 25-013, Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage, the financial responsibility for prescription drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx.²⁶ If the drugs are provided by the ICF/DD Home and billed on a medical or institutional claim, the MCP is responsible for payment.

For MCPs covering ICF/DD Home services effective January 1, 2024, and for any MCPs that do not include prescription drugs in their contracted ICF/DD Home rates, financial responsibility for prescription drugs is determined by claim type, as discussed above, since the Medi-Cal FFS ICF/DD Home per diem rate does not include legend drugs (prescription drugs).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.

MCPs must comply with PHM requirements, as outlined in Part IX below, in the MCP Contract, and in the PHM Policy Guide,²⁸ which include the coordination of Medically Necessary drugs or medications on behalf of the Member.

II. Network Requirements

Effective January 1, 2024, MCPs must have and maintain an adequate Network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes licensed and certified by the California Department of Public Health (CDPH). The Network must include at minimum one of each ICF/DD Home type within California, prioritizing ICF/DD Homes in the MCP's county when available. MCPs must assess Member utilization needs

²⁴ See APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses for more information.

²⁵ SPA 11-020 is available at:

<https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Recent%20Amendments%2011-020.pdf>.

²⁶ More information on the coverage of Medi-Cal pharmacy services is available through the current Medi-Cal Rx scope at:

<https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Medi-Cal-Rx-Scope.pdf>.

²⁷ 22 CCR sections 51510 and 51511.

²⁸ See the PHM Policy Guide, available at: <https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf>.

and use a data-driven approach to periodically monitor their Networks (i.e., out-of-Network requests, continuity of care, etc.). A list of approved and active ICF/DD Homes can be found on the CDPH website.²⁹

MCPs must streamline Credentialing and recredentialing processes for ICF/DD Homes in accordance with DHCS guidance in section XII. Credentialing of this APL and as detailed in the ICF/DD Carve-In Resource Guide.³⁰

MCPs must maintain an adequate Network of Providers to provide Medi-Cal covered services to ICF/DD Home residents. For example, an ICF/DD Home may be contracting with specialized occupational therapists who know how to provide services for individuals with intellectual and developmental disabilities. Using this example, DHCS expects MCPs to make every effort to contract with the occupational therapists serving these Members. MCPs must ensure that the Network Providers are equipped and appropriately trained to work with individuals with intellectual and developmental disabilities.

MCPs must have sufficient Network capacity to enable Member placement in an ICF/DD Home within five Working Days to no more than 14 calendar days of receiving the Prior Authorization request from the ICF/DD Home, according to the county of residence, as outlined in W&I section 14197.³¹

MCPs must ensure ICF/DD Home Providers undergoing a change of ownership provide verification they are undergoing such a process prior to the execution of a Network Provider Agreement. MCPs' Network Provider Agreements with ICF/DD Home Providers must have a clause stating ICF/DD Home Providers must notify the MCP whether it is undergoing a change of ownership so the ICF/DD Home can provide verification of the process.

In accordance with APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, MCPs must comply with requirements relating to CDPH initiated facility de-certifications and licensure suspensions. To ensure Members' health and safety, MCPs must work with Regional Centers to coordinate care and if necessary, work jointly to transition Members appropriately.

III. Leave of Absence and Bed Hold Requirements

²⁹ The list of approved and active ICF/DDs can be found on the CDPH's Cal Health Find Database, at:

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

³⁰ The ICF/DD Carve-In Resource Guide is available at:

<https://www.dhcs.ca.gov/ru/Documents/MCQMD/CalAIM-ICFDD-LTC-Carve-In-Resource-Guide.pdf>.

³¹ W&I section 14197.

MCPs must comply with regulations regarding leave of absence (LOA) and bed hold policies.³² MCPs must cover the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a Skilled Nursing Facility (SNF), or a rehabilitation facility, and then require a return to an ICF/DD Home.³³ According to these regulations, MCPs must include as a covered benefit any LOA or bed hold that an ICF/DD Home provides. MCPs must authorize up to 73 days per calendar year for an LOA. A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.³⁴ For a bed hold, MCPs must authorize up to a total of seven calendar days per hospitalization. The ICF/DD Home shall hold a bed vacant during the entire hold period – a maximum of seven days for each bed hold period³⁵ – but is not required to hold the bed if notified in writing by the attending physician that the patient requires more than seven days of hospitalization.³⁶ MCPs cannot require a separate authorization for a bed hold once an authorization for ICF/DD services is granted, provided that the Member returns to the same ICF/DD at the same level of care following an acute hospital stay of seven days or less.³⁷

Under the LOA and bed hold policies, which are detailed in 22 CCR sections 51535 and 51535.1, MCPs must allow the Member to return to the same ICF/DD Home where the Member previously resided if it is the Member's preference. MCPs must ensure the ICF/DD Home notifies the Member or the Member's Authorized Representative in writing of the right to exercise the bed hold provision. If a Member does not wish to return to the same ICF/DD Home following an LOA or approved bed hold period, the MCP must provide Care Coordination and transition support, including working with the assigned Regional Center, in order to assist the Member to identify another ICF/DD Home within the MCP's Network that can serve the Member. The Regional Center will take the lead on discharge and transition planning if the Member wishes to transition to a non Medi-Cal funded living situation with input from other stakeholders such as the hospital, the original ICF/DD Home, and the MCP. The MCP will take the lead on

³² See 22 CCR sections 51535 (Leave of Absence), 51535.1 (Bed Hold for Acute Hospitalization), and 76506 (Bed Hold).

³³ SNF and general acute care hospital are defined in H&S section 1250(a).

³⁴ The LOA, Bed Hold, and Room and Board section of the Medi-Cal Provider Manual Provider Manual (Part 2: Long Term Care) requires physician prescription for overnight LOAs in summer camps. See the Medi-Cal Provider Manual at: https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/FE5E3E2C-BD09-4A1A-8C42-036F13C17CFD/leave.pdf?access_token=6UyVkJRRfByXTZEWIh8j8QaYyIPyP5ULO

³⁵ 22 CCR section 51535.1(c)(2)

³⁶ 22 CCR section 51535.1(b)

³⁷ 22 CCR sections 51535.1 and 51535.1(c)(6).

discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care, in collaboration with the Regional Center.

The Regional Center service coordinator is the primary person interacting with the Member for the purpose of ensuring the Member receives the Regional Center funded services and supports identified in the IPP. They have lead administrative authority for facilitating living arrangements including ICF/DD Home arrangements. A Member's expression of interest in seeking services from a different ICF/DD Home must not result in expulsion from the previously serving ICF/DD Home.

IV. Continuity of Care Requirements

Members Who Resided in an ICF/DD Home prior to January 1, 2024, and Transitioned from Medi-Cal FFS to Medi-Cal Managed Care

ICF/DD Homes are a long-term home living setting, in which Members may spend months, years, or decades of life. Effective January 1, 2024, continuity of care ensured that a Member's ICF/DD Home would not change for at least 12 months while MCPs worked to bring the ICF/DD Homes into their Network. During the continuity of care period, MCPs automatically provided 12 months of continuity of care for the ICF/DD Home placement of any Member who resided in an ICF/DD Home and was mandatorily enrolled into an MCP after January 1, 2024.

Automatic continuity of care meant that Members residing in an ICF/DD Home did not have to request continuity of care to continue to reside in the ICF/DD Home. MCPs were required to automatically initiate the continuity of care process prior to the Member's transition to the MCP. MCPs were required to determine if Members were eligible for automatic continuity of care before the transition by identifying the Member's ICF/DD Home residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS.

While Members were required to meet Medical Necessity criteria for ICF/DD services, continuity of care was to be automatically applied. Medical Necessity was determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. The HS 231³⁸, DHCS 6013 A³⁹ and the MCP ICF/DD Authorization Request

³⁸ Form HS 231 is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E3C0332D-4A0B-4366-96B6-AA734CC3205C/dhcs0231-certification-for-special-treatment-program-services.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO.

³⁹ DHCS Form 6013 A is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/39FFA4DB-4B59-433F-B5C9-05B94C298B4A/6013a_prolonged_care_assessment.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO.

Form,⁴⁰ or the data field on the form, were considered sufficient information to determine Medical Necessity; however, if documentation was lacking, the MCP was required to request additional supporting documents to substantiate Medical Necessity. The Regional Center's determination of Medical Necessity stood for both initial authorizations and reauthorizations.

MCPs were required to allow these Members to stay in the same ICF/DD Home under continuity of care if the Member chose to continue living in the ICF/DD Home and all of the following applied:

- The ICF/DD Home was licensed by CDPH;
- The ICF/DD Home was enrolled as a Medi-Cal Provider;
- The MCP paid the ICF/DD Home payment rates that met state statutory requirements;⁴¹ and
- The ICF/DD Home met the MCP's applicable professional standards and had no disqualifying Quality of Care issues.

Following their initial 12-month continuity of care period, Members or their Authorized Representatives were permitted to request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or after January 1, 2023.

Members Residing in an ICF/DD Home Who Newly Enrolls in an MCP on or after January 1, 2024

A Member residing in an ICF/DD Home who newly enrolls in an MCP on or after January 1, 2024, or their Authorized Representative, who wishes to request an additional 12 months of continuity of care must follow the process established by APL 23-022. MCPs must notify the Member, or their Authorized Representative, and furnish a copy of the notification to the ICF/DD Home in which the Member resides, of their right to request continuity of care, consistent with APL 23-022.

Under continuity of care, Members may continue seeing their out-of-Network Medi-Cal Provider if the Member, Authorized Representative, or Provider contacts the new MCP to make the request. MCPs must provide continuity of care for all Medically Necessary ICF/DD Home services for Members residing in an ICF/DD Home at the time of enrollment in an MCP including professional services, ancillary services, and transportation services not already provided in the ICF/DD Home per diem rate. MCPs

⁴⁰ The MCP ICF/DD Authorization Request Form is available on the DHCS website as an attachment to this APL.

⁴¹ W&I section 14184.201(c).

must also provide the appropriate level of Care Coordination, as outlined in this APL and in adherence to contractual requirements.

Members may continue seeing their existing out-of-Network Medi-Cal Provider for up to 12 months after enrollment when the following conditions are met:

- The Member has a pre-existing relationship with the Provider, defined as having seen the Provider for at least one non-emergency visit in the prior 12 months.
- The Provider meets the MCP's professional standards and has no disqualifying Quality of Care issues; and
- The Provider is willing to work with the MCP (i.e., agree on payment and/or rates).

A Member may not simply attest to a preexisting relationship and, instead, must provide actual documentation which may be provided by the ICF/DD Home, unless the MCP makes an attestation option available to the Member. A pre-existing relationship means the Member resided in an ICF/DD Home at some point during the 12 months prior to the date of the Member's enrollment in the MCP.

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 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.

Continuity of care also provides continued access to the following services but may require a switch to Network Providers: NEMT and NMT, facility services, professional services, select ancillary services, and appropriate level of Care Coordination. MCPs must make every effort to ensure continued access to care to Providers that have experience and expertise in working with Members with developmental disabilities.

If a Member is unable to access continuity of care as requested, the MCP must provide the Member, or their Authorized Representative, with written notice of action of an Adverse Benefit Determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates.

MCPs must also comply with the requirements in H&S section 1373.96, W&I section 14186.3(c)(4), and 28 CCR section 1300.67.1. MCPs must provide continuity of care pursuant to H&S section 1373.96 for Members receiving LTC services who transition

from one MCP to another.⁴² MCPs must also retroactively approve a continuity of care request and reimburse Providers for services that were already provided if the request meets all continuity of care requirements outlined in APL 23-022.

V. Treatment Authorization and Prior Authorization Requests

Effective January 1, 2024, MCPs are responsible for Treatment Authorization Requests (TARs) approved by DHCS for ICF/DD Home services provided under the ICF/DD Home per diem rate for the duration of the treatment authorization for existing TARs and for up to two years for any new requests.⁴³

MCPs are responsible for all other approved TARs for services in an ICF/DD Home, exclusive of the ICF/DD Home per diem rate for a period of 90 days after enrollment in the MCP, or until the MCP is able to reassess the Member and authorize and connect the Member to Medically Necessary services.

Routine authorizations are subject to a turnaround time of five working days.⁴⁴

Effective January 1, 2024, ICF/DD Homes must submit the Certification for Special Treatment Program Services form HS 231 to MCPs with any Prior Authorization or reauthorization requests. MCPs must accept the Certification for Special Treatment Program Services form HS 231 as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care. Prior Authorization may be granted for periods up to two years from the date of admission. Reauthorizations may also be granted for up to two years.

⁴² 42 Code of Federal Regulations (CFR) section 438.62(b). The CFR is searchable at: <https://www.ecfr.gov/>.

⁴³ See the Medi-Cal Provider Manuals at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care>.

⁴⁴ H&S section 1367.01

MCPs and ICF/DD Homes are required to follow the Medi-Cal Provider Manual and statutory and regulatory requirements related to LTC services for ICF/DD Home services.^{45, 46, 47, 48}

Whenever a reauthorization of ICF/DD-N Home services is being requested, the ICF/DD-N Home must submit a copy of the Member's ISP. ISP submissions are required as part of the periodic review of ICF/DD-N Homes.⁴⁹ MCPs must not require reauthorizations for ICF/DD Home services for Members that transfer from an ICF/DD Home to an acute care hospital, are placed on a bed hold, and then return to the same ICF/DD Home within seven days or less.⁵⁰

In instances where the Member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated Prior Authorization request that includes the changed dates of service.

MCPs must ensure that payment is made in accordance with the service provided based on revenue codes in contractual agreements. MCPs should include revenue codes on all Prior Authorizations, and ensure Prior Authorizations state the MCP, Subcontractor, or Downstream Subcontractor responsible for payment of any related claims.

VI. ICF/DD Home Payment Rate

In accordance with W&I section 14184.201(c)(2), for Contract periods from January 1, 2024, to December 31, 2025, inclusive, each MCP must reimburse a Network Provider furnishing ICF/DD Home services to a Member, and each Network Provider of ICF/DD Home services must accept, the payment amount the Network Provider would be paid

⁴⁵ The relevant Medi-Cal Provider Manuals are available at:

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3D7C4E9A-1B31-48BF-BDD0-CA0241B81192/ratefacil.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO and https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/EE176E40-D10D-4AC3-8F60-C72EE0AAC5CB/incont.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO.

⁴⁶ The HS 231 form can be found at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E3C0332D-4A0B-4366-96B6-AA734CC3205C/dhcs0231-certification-for-special-treatment-program-services.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO. The MCP ICF/DD Authorization Request Form is available on the DHCS website as an attachment to this APL.

⁴⁷ See 22 CCR sections 51510 (Payment for Services and Supplies—Nursing facility Level A services), 51510.1 (Payment for Services and Supplies-ICF DD), 51510.2 (Payment for Services and Supplies-ICF DD/H), 51510.3 (Payment for Services and Supplies-ICF DD/N), and 51526 (Incontinent Medical Supplies).

⁴⁸ W&I section 14131.10.

⁴⁹ See the Medi-Cal Provider Manual at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care>.

⁵⁰ See 22 CCR sections 51535.1 and 51535.1(c)(6).

for those services in the FFS delivery system, as defined by DHCS in the Medi-Cal State Plan and as authorized by W&I sections 14105.075(b) and 14184.102(d). As authorized by W&I section 14184.201(b)(2), DHCS has elected to extend this requirement through December 31, 2026. DHCS may elect to extend this requirement for future Rating Periods through subsequent APLs.⁵¹

This reimbursement requirement is subject to the Centers for Medicare and Medicaid Services' (CMS) approval as a state-directed payment arrangement in accordance with 42 CFR section 438.6(c) and is subject to future budgetary authorization and appropriation by the California Legislature.

In counties where ICF/DD Home services benefit coverage transitioned from the Medi-Cal FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2024,⁵² MCPs must reimburse Network Providers of ICF/DD Home services for those services at **exactly** the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home services Provider for dates of service from January 1, 2024, through December 31, 2026, in accordance with W&I section 14184.201(c)(2), this APL, and the terms of the CMS-approved directed payment preprint.⁵³

In counties where ICF/DD Home services were already Medi-Cal managed care Covered Services prior to January 1, 2024, MCPs must reimburse Network Providers of ICF/DD Home services for those services at **no less than** the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home services Provider for dates of service from January 1, 2024, through December 31, 2026, in accordance with W&I section 14184.201(c)(2), this APL, and the terms of the CMS-approved state directed payment preprint as applicable.⁵⁴

These state-directed payment requirements only apply to inclusive per diem ICF/DD Home services as defined in 22 CCR sections 51510.1, 51510.2, and 51510.3, as applicable, and listed in Attachment A, starting on the first day of a Member's living arrangement. They do not apply to any other services provided to a Member living in an

⁵¹ FFS per diem Rates on File for LTC facilities are available at https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.ICF_DD.aspx.

⁵² This requirement applies to MCPs in the following 36 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.

⁵³ FFS per diem rates for ICF/DD, ICF/DD-H, and ICF/DD-N are available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.ICF_DD.aspx.

⁵⁴ This requirement applies to MCPs in the following 22 counties: 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.

ICF/DD Home including, but not limited to, services outlined in 22 CCR section 51165(b), services provided by any out-of-Network Provider, and any services that are not provided by a Network Provider of ICF/DD Home services at the per diem rate. Payments for such non-qualifying services, as well as payments that are not directly for ICF/DD Home services rendered such as Provider incentive and pay-for-performance payments, are not subject to the state-directed payment requirements.

VII. Payments Processes Including Timely Payment of Claims

MCPs must provide a process for Network Providers to both submit electronic claims and receive payment electronically if a Network Provider requests electronic processing including, but not limited to, processing automatic crossover payments for Members who are dually eligible for Medicare and Medi-Cal. MCPs must allow an invoicing process with minimum necessary data elements for ICF/DD Homes unable to submit electronic claims. See Billing and Invoicing Guidance for agreed-upon data elements that MCPs and ICF/DD Homes must use for the invoicing process.⁵⁵

MCPs, including all Subcontractors and Downstream Subcontractors, must make timely payments in accordance with the prompt payment standards within the MCP Contract and APL 23-020, Requirements for Timely Payments of Claims. DHCS expects MCPs to pay Clean Claims within 30 calendar days of receipt. MCPs are highly encouraged to pay claims and invoices in the same frequency in which they are received (e.g., weekly, monthly), whether electronic or paper claims.

Medi-Cal FFS per diem rates may be updated by DHCS for specified dates of service. The Medi-Cal FFS per diem rate published for the latest dates of service remains effective for subsequent dates of services, until such time that an updated per diem rate is published for subsequent dates of service. MCPs must implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of service, received on or after 30 Working Days of being notified by DHCS that the updated rates are published. If additional amounts are owed retroactively in accordance with this APL and the terms of this state directed payment to a Network Provider of ICF/DD Home services on any claims for applicable dates of service that were processed prior to the MCP implementing the updated per diem rates on a prospective basis, then MCPs must pay any necessary retroactive adjustments within 45 Working Days after being notified by DHCS that the updated rates are published.⁵⁶ MCPs must retroactively reprocess claims for specified dates of service to effectuate the updated rate

⁵⁵ Available on the DHCS CalAIM ICF/DD LTC Carve-In webpage at:

<https://www.dhcs.ca.gov/provgovpart/Pages/Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In.aspx>.

⁵⁶ Rates are accessible from the DHCS LTC reimbursement webpage at:

https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.ICF_DD.aspx.

automatically, without requiring manual reprocessing or resubmission by the Network Provider. MCPs are expected to comply with these reimbursement requirements immediately upon issuance of this APL. If, because of a retroactive decrease in the published rate, amounts previously paid by an MCP are owed retroactively by the Provider to the MCP in accordance with this APL and the terms of this state directed payment, then the MCP must recoup such amounts in a timely manner, but no later than within 365 calendar days after being notified by DHCS that the updated rates are published. This retroactive adjustment shall not be considered an overpayment for the purposes of 28 CCR section 1300.71(b)(5).

For the purposes of timely payment requirements specified in APL 23-020, effective for dates of service on or after January 1, 2026, any additional amount owed retroactively in accordance with this APL is considered a portion of a claim as described in H&S section 1371. An MCP owes the Provider interest on any unpaid additional amount owed at the rate of 15 percent per annum beginning on the first calendar day after the latter of:

1. 45 Working Days of being notified that the updated rates applicable to the claim have been published by DHCS, as described above.
2. 30 calendar days of receipt of claims.⁵⁷

The MCP must automatically include all accrued interest in any late payment. This paragraph does not relieve the MCP of any other interest that may be owed on any other portion of a claim under APL 23-020 or applicable state and federal law.

MCPs must ensure that the Network Providers of ICF/DD Home services receive reimbursement in accordance with the above requirements for all qualifying services regardless of any Subcontractor arrangements.

While these are the minimum requirements, MCPs are not precluded from advancing payments to ICF/DD Homes and reconciling to the paid amounts based on what the providers have appropriately billed, particularly at the start of the transition so that ICF/DD Homes can get accustomed to the MCPs' claims payment processes and MCPs can ensure timely payment and cash flow to ICF/DD Homes.

Payments processes including timely payment of claims requirements for Network Providers also apply for out-of-Network Providers when those dates of service are under continuity of care.

⁵⁷ Note, Assembly Bill 3275 (Stats. 2024, Ch. 763) amended the requirement in H&S section 1371 effective January 1, 2026. Please see Department of Managed Health Care APL 25-007: Assembly Bill 3275 Guidance (Claim Reimbursement) available at [https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-007-AssemblyBill3275Guidance\(Claim%20Reimbursement\)\(4 1 2025\).pdf?ver=i37HpYGfgP6BHL3ghvJ4QQ%3d%3d](https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-007-AssemblyBill3275Guidance(Claim%20Reimbursement)(4%2025).pdf?ver=i37HpYGfgP6BHL3ghvJ4QQ%3d%3d) for further guidance.

MCP Contracts require the MCPs to have a formal Provider dispute resolution process. DHCS specifies that MCPs must have a formal procedure to accept, acknowledge, and resolve Provider disputes related to the reimbursement of ICF/DD Home services, including compliance with any applicable Medi-Cal FFS per diem rate requirements and the processing of prospective and retroactive rate adjustments. MCPs must accept Provider disputes related to retroactive rate adjustments as timely, without regard to the underlying date of service or claim submission, if the Provider alleges that the MCP has failed to effectuate the retroactive rate adjustment or pay any required interest within the timeframe required by this APL. MCPs must track the number of Providers who initiate the Provider dispute resolution process, the disposition of those disputes, and the time frames for resolution and/or final disposition. DHCS may request information regarding the Provider disputes and how they were resolved. MCPs must maintain records to respond to DHCS's request for information regarding Provider disputes.

VIII. Share of Cost

MCPs must process claims submitted by ICF/DD Homes consistent with the Medi-Cal guidelines for SOC outlined in the Medi-Cal LTC Provider Manual.⁵⁸ When a Member has an SOC, the ICF/DD Home will subtract the SOC payment collected or obligated payment from the claim amount and submit the claim to the MCP to pay the balance.

Also, the Johnson v. Rank settlement⁵⁹ allows Medi-Cal members, not their Providers, to elect to use the SOC funds to pay for necessary, non-covered, medical or remedial care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the Medi-Cal member's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the Medi-Cal member's medical record. If a Medi-Cal member spends part of their SOC on necessary, non-covered, medical or remedial care services or items, the ICF/DD Home will subtract those amounts from a Medi-Cal member's SOC and collect the remaining SOC amount owed. The ICF/DD Home will adjust the amount on the claim and submit the claim to the MCP to pay the balance. Further DHCS guidance regarding Johnson v. Rank requirements is available in the Medi-Cal LTC Provider Manual.

ICF/DD Homes that collect SOC payments or obligated payments are responsible for certifying SOC in the Medi-Cal eligibility verification system to show the Medi-Cal member has paid the SOC or has an obligated payment for the monthly SOC amount owed. Instructions for Providers to perform SOC clearance transactions in the Medi-Cal eligibility verification system are provided in Part 1 of the Medi-Cal Provider Manual.

⁵⁸ Provider Manuals are available at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual>.

⁵⁹ A summary of the settlement is available at: <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c89-54.pdf>.

IX. Population Health Management Requirements

As required under the Lanterman Act, each Member living in an ICF/DD Home has a Regional Center service coordinator assigned to them. The service coordinator builds and sustains an ongoing relationship with the Member and their family through facilitation of the IPP process. Through this process, the service coordinator assists the Member and their family members in identifying needs and accessing services and resources, including from other agencies, including generic services when applicable. The Regional Center service coordinator is the primary person interacting with the Member and is the person ensuring the Member receives the services identified in the IPP.

Effective January 1, 2024, MCPs are required to coordinate and work with Regional Centers in the identification of services that will be provided to the Member by the MCP. The goal is to reduce any duplication of effort or work among the MCPs and Regional Centers, and to ensure MCPs are fully aware of the Member's needs and the services to be provided by the MCPs and Regional Centers. It is the Regional Centers' duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPPs. MCPs must inform the Regional Centers of which services will be provided by MCPs. A Memorandum of Understanding between Regional Centers and MCPs that includes coordination for Members living in ICF/DD Homes will support this effort.

Effective January 1, 2024, MCPs were required to implement a PHM Program ensuring all Medi-Cal managed care Members, including Members living in ICF/DD Homes, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports, as appropriate and in coordination with the Regional Center.

BPHM applies an approach to care that ensures needed programs and services, including Primary Care Providers and specialists, are made available to each Member. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP Members receive BPHM, regardless of their level of need.

As part of their PHM Program, MCPs must provide strengthened TCS.⁶⁰ TCS for high-risk Members was instituted January 1, 2023.⁶¹ Effective January 1, 2024, TCS are required for all Members, regardless of risk status. Effective January 1, 2024, MCPs must ensure that

⁶⁰ More information on TCS for Members with Long Term Services and Supports (LTSS) needs is available at: <https://www.dhcs.ca.gov/CalAIM/Documents/TCS-TA-Resource-for-LTSS-Transitions.pdf>.

⁶¹ Members receiving LTSS, including those in an institutional setting, are one of the groups considered to be "high risk". CMS classifies Intermediate Care Services as an institutional service.

Prior Authorization determinations are rendered in a timely manner for all Members and have a process to track when all Members are admitted, discharged, or transferred from facilities, including ICF/DD Homes. The PHM Policy Guide notes that high risk individuals include individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability.⁶² TCS include assigning a single point of contact, referred to as a care manager, to assist Members throughout their transition and ensure all required services are complete.

MCPs and their assigned care managers must ensure Member transitions to and from an ICF/DD Home are timely and do not delay or interrupt any Medically Necessary care.

Care management beyond transitions includes two programs: (1) Complex Care Management (CCM); and (2) Enhanced Care Management (ECM). If a Member is enrolled in either CCM or ECM, TCS must be provided by the Member's assigned care manager. MCPs must also continue to provide all elements of BPHM to Members enrolled in care management programs.

CCM is a service for managed care Members who need extra support to avoid adverse outcomes, but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic Care Coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner.

ECM is a whole-person, interdisciplinary approach to comprehensive care management for managed care Members who meet the Populations of Focus criteria. It is intended to address the clinical and non-clinical needs of high-cost, high-need Members through systematic coordination of services and it is community-based, interdisciplinary, high touch, and person-centered.

Members living in ICF/DD Homes are eligible for BPHM, TCS, and Targeted Case Management as applicable. While they are not currently eligible for ECM, if there are other individual care needs or concerns, their needs can be reviewed for consideration. If a Member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the Member must be assessed to determine need/eligibility for ECM services.

A Member can receive appropriate Community Supports if they are eligible for specific Community Supports and the MCP offers Community Supports. Community Supports are offered in place of State Plan benefits or settings. TCS are generally not duplicative

⁶² See the PHM Policy Guide, at: <https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf>.

of Community Supports but the MCP will be responsible for ensuring there is no duplication of services and/or payment.

For more information about PHM, please refer to the DHCS PHM website⁶³; the PHM Policy Guide⁶⁴; APL 22-024; and the MCP Contract. For more information about ECM or Community Supports, please refer to the DHCS ECM and Community Supports webpage⁶⁵; APL 23-032; APL 21-017; the Finalized ECM and Community Supports MCP Contract Template⁶⁶; the ECM Policy Guide⁶⁷; and the Community Supports Policy Guides.⁶⁸

X. Quality Monitoring and Reporting

MCPs are responsible for monitoring quality and appropriateness of care provided to Members who reside at contracted ICF/DD Homes through the establishment of an ICF/DD Home's quality assurance program. MCPs should establish a mechanism to receive ICF/DD Homes' oversight and compliance findings and data from CDPH, as well as service delivery findings from the Regional Centers, through the MCPs' and Regional Centers' executed Memoranda of Understanding so that information can be included in the quality assurance program. Upon DHCS request, MCPs must submit quality assurance reports with outcome and trending data.

XI. Policies and Procedures

Within 90 days of the release of this APL, MCPs must update and submit their policies and procedures (P&Ps) to include all requirements in this APL to the Managed Care Operations Division (MCO)D-MCP Submission Portal.⁶⁹ In addition, MCPs must submit

⁶³ See the DHCS PHM Webpage, at:

<https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx>.

⁶⁴ See the PHM Policy Guide, at: <https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf>.

⁶⁵ See the ECM and Community Supports Webpage, at:

<https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx>.

⁶⁶ See the ECM and Community Supports Template, at:

<https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf>.

⁶⁷ See the ECM Policy Guide, at: <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf>.

⁶⁸ Volume 1 of the Community Supports Policy Guide is available at:

<https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf>.

Volume 2 of the Community Supports Policy Guide is available at:

<https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf>.

⁶⁹ The MCO)D-MCP Submission Portal is located at: [https://cadhcs.sharepoint.com/sites/MCO\)D-MCPSubmissionPortal/SitePages/Home.aspx](https://cadhcs.sharepoint.com/sites/MCO)D-MCPSubmissionPortal/SitePages/Home.aspx).

any P&Ps required in any DHCS deliverables lists for LTC to their MCO Contract Manager.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose enforcement actions, including corrective action plans, as well as administrative and/or monetary sanctions for non-compliance. MCPs must review their Subcontractor, Downstream Subcontractor, and Network Provider Agreements to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007. Any failure to meet the requirements of this APL may result in enforcement actions.

XII. Long-Term Services and Supports Liaison

MCPs, including all Subcontractors and Downstream Subcontractors, 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 long-term institutional care, including payment and coverage policies; prompt claims payment requirements; provider dispute resolution P&Ps; and care management, Care Coordination and TCS policies. LTSS liaisons must serve as a single point of contact for service providers in both a Provider representative role and 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 a non-licensed or paraprofessional. MCPs must identify these individuals and disseminate their contact information to their Network Providers. Per the MCP Contract, MCPs must notify Network Providers of changes to LTSS liaison assignment expeditiously in order to ensure coordination and services offered to Members, but no later than the date of change and must notify DHCS within five days of the change.

Beginning in calendar year 2026, each MCP must hold an "office hours" webinar at least once per calendar quarter for all eligible Network Providers furnishing LTC services to present updates related to P&Ps pertaining to LTC services and answer frequently asked questions, including but not limited to, payment and coverage policies, prompt claims payment requirements, Provider resolutions P&Ps, and care management, coordination and transition policies. The webinar must allow these Network Providers to participate virtually via telephone and optionally via an online teleconference service. The webinar must provide the capability and opportunity for Network Providers to ask live questions.

At least 30 days before the webinar, each MCP must publish, on a public internet website, the date and time of the webinar and instructions to join and notify all applicable Network Providers. DHCS may provide additional guidance to MCPs regarding the required timing, content, and duration of webinars.

XIII. Credentialing

DHCS allows MCPs to deem ICF/DD Homes credentialed via attestation if the ICF/DD Homes' state regulatory processes are current. To meet MCP Credentialing requirements, ICF-DD Homes must submit:

- An ICF/DD Attestation⁷⁰ under penalty of perjury that the following Credentialing requirements are satisfied:
 - Completion of the MCP's specific Provider Training within the last two (2) years
 - Facility Site Audit from State Agency
 - No Change in 5% Ownership Disclosure since the last submission to MCP
 - Possess an active CDPH License and CMS Certification
 - In good standing as a Regional Center Vendor

Recredentialing is to occur every two years through re-submission of an ICF/DD Attestation. If an ICF/DD Home has a change to any requirement attested to between the years ICF/DD Homes are to be recredentialed, an ICF/DD Home must report that change to their MCPs along with any required documentation within 90 days of when the change occurred.

For the initial Credentialing, ICF/DD Homes must submit the below items in addition to the ICF/DD Attestation:

- W-9 Request for Taxpayer Identification Number and Certification
- MCP Ancillary Facility Network Provider Application
- Certificates of Insurance (Professional and General Liability)
- City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)
- 5% Ownership Disclosure

This streamlined policy is in effect until DHCS reassesses the risk level for ICF/DD Homes. At such time, DHCS may require MCPs to complete full Credentialing with ICF/DD Homes.

XIV. Additional Guidance

1. ICF/DD Homes Provider Model Contract

⁷⁰ The ICF/DD Attestation is available on the DHCS website as an attachment to this APL.

MCPs are required to incorporate the standard terms and conditions provided by DHCS, in addition to their own terms, to develop their contracts with ICF/DD Home Providers.⁷¹ If the MCP's contract substantially deviates from these terms and conditions, MCPs are required to submit to DHCS for review and approval.

2. Billing and Invoicing Guidance

MCPs should remit claims and invoices as they are received.

MCPs must allow ICF/DD Homes to submit invoices if the ICF/DD Home is unable to submit claims electronically. DHCS issued Billing and Invoicing Guidance that provides standard "minimum necessary" data elements MCPs will need to collect from ICF/DD Homes unable to submit ANSI ASC X12N 837P claims to MCPs.⁷²

If you have any questions regarding this APL, please contact your MCO Contract Manager.

Sincerely,

Original Signed by Dennis Hsieh

Dennis Hsieh

Chief, Managed Care Quality and Monitoring Division

⁷¹ The standard terms and conditions are located in the Model Contract, which is posted on the ICF/DD Carve-In webpage, at: <https://www.dhcs.ca.gov/provgovpart/Pages/Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In.aspx>.

⁷² The DHCS Billing and Invoicing Guidance is posted on the ICF/DD Carve-In webpage, at: <https://www.dhcs.ca.gov/provgovpart/Pages/Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In.aspx>.

LTC/DD Carve-In:

Summary of Inclusive/Exclusive Services

Attachment A

Below is summary of services included in the per diem rate ICF/DD, ICF/DD- H, and ICF/DD-N, per state guidelines. These tables are not meant to be exhaustive. Please see sources for additional information.

Summary of Services Included/Excluded in ICF/DD Carve-In Per Diem Rate

Included Services in ICF/DD Per Diem Rate
Summary: All services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria
Active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services per 42 CFR section 483.440
Case conference review of member's developmental needs
Joint development of individual service plans
In-service training of direct care staff and follow-up to ensure proper implementation of individual service plan
Advising on the need for provision of various types of intervention or specialized equipment beyond the capabilities of the facility or staff
Administrative services ⁷³
Health support, food and nutritional and pharmaceutical services ⁷⁴
Social services
The provision of routine and emergency drugs and biologicals to its members. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy
Services usually required by persons with developmental disabilities. However, actual programs provided to members shall be based on the specific needs identified through member assessments.

⁷³ 22 CCR sections 76907-76931.

⁷⁴ 22 CCR sections 76817-76906.

Included Services in ICF/DD Per Diem Rate
- Examples include sensory motor development, self-help skills training, and behavioral intervention programs
Transportation services when necessary for round trips to attending physicians ⁷⁵
Habilitation program which shall include recreation, education, and effective use of leisure time and socialization skills ⁷⁶
Early and periodic screening and diagnosis and treatment (EPSDT) ⁷⁷
Specific equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria ^{***}

***Inclusive of only ICF/DD-N. "Specific equipment and supplies" refers to equipment and supplies that can be used by more than one person that are necessary to provide Level of Care for this type of facility. Equipment that is specific to an individual and cannot be used by others is excluded from per diem (i.e., custom wheelchair)

Excluded Services in ICF/DD Per Diem Rate
Allied health services ordered by the attending physician
Alternating pressure mattresses/pads with motor
Atmospheric oxygen concentrators and enrichers and accessories (except as specified)
Blood, plasma, and substitutes
Dental services
Durable medical equipment, including wheelchairs designed for one person, as specified in 22 CCR section 51321(g) and (h) (except as specified)
Incontinence supplies for Medi-Cal members ages 5 or more whose developmental deficits are such that bowel and bladder control cannot be attained (for ICF/DD-H and ICF/DD-N)

⁷⁵ 22 CCR section 51343.1.

⁷⁶ 22 CCR section 51343.1(e).

⁷⁷ 22 CCR section 51340.

Excluded Services in ICF/DD Per Diem Rate
Insulin
Intermittent positive pressure breathing equipment
Intravenous trays, tubing and blood infusion sets
Laboratory services (except as specified)
Legend drugs
Liquid oxygen system
MacLaren or Pogon Buggy
Medical supplies as specified in the list established by DHCS
Nasal cannula
Osteogenesis stimulator device
Oxygen (except emergency)
Parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Medi-Cal member
Physician services
Portable aspirator
Portable gas oxygen system and accessories
Precontoured structures (VASCO-PASS, cut out foam)
Prescribed prosthetic and orthotic devices for exclusive use of patient
Reagent testing sets
Therapeutic air/fluid support systems/beds
Traction equipment and accessories
Transportation for day and related transportation services ⁷⁸
Variable height beds

⁷⁸ For more information on Transportation Services, see DHCS' Transportation Services webpage at: <https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx> and APL 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

Excluded Services in ICF/DD Per Diem Rate

X-rays (except as specified)

Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

All services and supplies billed separately are subject to the general provisions and benefit limitations set forth in 22 CCR sections 51303 and 51304.

Sources:

- [Medi-Cal Provider Manual, Rates: Facility Reimbursement - Miscellaneous Inclusive and Exclusive Items](#)
- [Medi-Cal Rx Scope](#)

Additional Resources:

- Medi-Cal State Plan: [Limitations on Attachment 3.1-B](#)
- Medi-Cal State Plan: [Attachment 4.19-D](#) Methods and Standards for Payment Rates - Skilled Nursing and Intermediate Care Facility Services
- [Frequently Asked Questions from ICF/DD Providers about the ICF/DD SPA – CA Department of Developmental Services](#)
- [April 1, 2011 Letter to ICF/DD, DD-H and DD-N Providers Regarding the State Plan Amendment \(ca.gov\).](#)

ICF/DD State Plan Amendment (SPA) 07-004/[SPA 11-020](#). The Regional Center authorizes and pays for day and transportation services as reflected on the individual's IPP and bills the cost of those services to DDS, on behalf of the ICF/DD Home. DDS then pays the ICF/DD Home the supplemental payment.