CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: November 28, 2023

ALL PLAN LETTER 23-023 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO 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.[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. Revised text is found in *italics*.

"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 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).

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[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 Transition, 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.

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) is implementing benefit standardization – also termed a "carve-in" – of the ICF/DD Home benefit statewide.[7]

Currently, only County Organized Health System (COHS) MCPs cover ICF/DD benefits under the institutional LTC services benefit. At present, Members receiving ICF/DD services in non-COHS counties are served through Medi-Cal FFS. Pursuant to Medi-Cal's benefit standardization policy, beginning January 1, 2024, Members who reside in an ICF/DD Home will remain enrolled in managed care, instead of being disenrolled from the MCP and transferred to FFS Medi-Cal. Members who are residing in an ICF/DD Home will be transferred from FFS Medi-Cal to Medi-Cal managed care.[8]

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[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, or any superseding APL, 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.

1. Member Rights Through the Lanterman Act[9]

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 the Department of Developmental Services (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

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

> 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 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]

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[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.

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.

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]

3. MCP Readiness

DHCS will ensure MCP readiness before the transition of these populations into managed care. Readiness includes, but is not limited to, requiring MCPs – including COHS MCPs – to submit data and information to DHCS to confirm there is an adequate Network in place to meet anticipated utilization for their Members. Additionally, a deliverables matrix has been provided to MCPs with all plan readiness requirements.

POLICY:
Effective January 1, 2024, DHCS will require Non-Dual and Dual LTC Members (including those with Medi-Cal Share of Cost 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 will remain the same.

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[16] Information on the Client Assessment can be found in 22 CCR section 76859.
[17] W&I section 4512(a).

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 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 California Code of Regulations (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 care coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, or any superseding APL. Such coordination of benefits must include recognizing OHC as primary and the Medi-Cal program as the payer of last resort by exercising cost avoidance and conducting post-payment

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[18] See the PHM Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.
[19] See the Medi-Cal Provider Manual, at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care.
[20] Form HS 231 is available at: *https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7F3DBDBF-4A2D-4779-AAEA-9EBA2873CBC6/hs_231.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.*

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.

MCPs will cover 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]

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

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

Consistent with guidance in APL 22-012, Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx, or any superseding APL, 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 MCPs newly 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 Readiness Requirements

DHCS issued ICF/DD Home Network readiness requirements guidance separately to the MCPs via email on May 31, 2023, in the document titled Intermediate Care Facility for Developmental Disabilities Network Readiness Requirements along with a reporting template.

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[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/MediCal-Rx-Scope-V06-2-8-2022.pdf.
[27] 22 CCR sections 51510 and 51511.
[28] See the PHM Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

Effective January 1, 2024, MCPs will be required to 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) and report their contracting status at the time of Network submission. MCPs with contracting efforts in progress or contracts not yet active can provide evidence of such efforts. The Network must include at minimum one (1) 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 and use a data-driven approach to periodically monitor their Networks to ramp up Network adequacy (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 Resource* Guide document.

MCPs must also make every effort to assess the various provider types currently serving ICF/DD Home residents receiving Medi-Cal covered services and maintain an adequate Network with them. For example, an ICF/DD Home may currently be contracting with specialized occupational therapists who know how to provide services for individuals with intellectual and developmental disabilities and those providers may bill Medi-Cal directly on a FFS basis. Using this example, DHCS expects MCPs to make every effort to contract with the occupational therapists currently serving these Members to ensure care is not disrupted. If all efforts to contract with providers currently working with Members have been exhausted, then the MCP may offer the Member a choice of a Network Provider to transition services. MCPs must ensure that the Network Providers are equipped and appropriately trained to work with individuals with intellectual and developmental disabilities.

MCPs must ensure that timely access to the ICF/DD Home benefit is available within five to no more than 14 calendar days of receiving the authorization request from the ICF/DD Home, according to the county of residence, as outlined in Welfare and Institutions Code (W&I) section 14197.[30]

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[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] W&I section 14197.

MCPs must ensure contracted ICF/DD Home Providers receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for ICF/DD Home Providers undergoing a change of ownership. 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 obtain preapproval or assessment of suitability from CDPH.

In accordance with APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, or any superseding APL, 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

MCPs must comply with regulations regarding leave of absence (LOA) and bed hold policies.[31] 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.[32] 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 a LOA. *A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.*[33] For a bed hold, MCPs must authorize up to a total of 7 *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 period*[34] *– but is not required to hold the*

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[31] See 22 CCR sections 51535 (Leave of Absence), 51535.1 (Bed Hold for Acute Hospitalization), and 76506 (Bed Hold).
[32] SNF and general acute care hospital are defined in H&S section 1250(a).
[33] *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.cammis.medi-cal.ca.gov/assets/FE5E3E2C-BD09-4A1A-8C42-036F13C17CFD/leave.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO*
[34] *22 CCR section 51535.1(c)(2)*

bed if notified in writing by the attending physician that the patient require more than seven days of hospitalization.[35]

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 a 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 stakeholder such as the hospital, the original ICF/DD Home, and the MCP. The MCP will take the lead on 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: ICF/DD Home Living Arrangement

ICF/DD Homes are a long-term home living setting, in which Members may spend months, years, or decades of life. Continuity of care ensures that a Member's ICF/DD Home will not change for at least 12 months while MCPs work to bring the ICF/DD Homes into their Network. During the continuity of care period, MCPs must automatically provide 12 months of continuity of care for the ICF/DD Home placement of any Member residing in an ICF/DD Home who is mandatorily enrolled into an MCP after January 1, 2024.

Automatic continuity of care means that Members currently residing in an ICF/DD Home do not have to request continuity of care to continue to reside in the ICF/DD Home. Instead, MCPs must automatically initiate the continuity of care process prior to the

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[35] *22 CCR section 51535.1(b)*

Member's transition to the MCP. MCPs must determine if Members are 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. DHCS will provide *Medi-Cal member* utilization and treatment authorization request (TAR) data to MCPs in November 2023.

While Members must meet Medical Necessity criteria for ICF/DD services, continuity of care must be automatically applied. Medical Necessity is determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. The HS 231[36], DHCS 6013 A[37] and *the MCP ICF/DD Authorization Request Form,[38] or the data field on the form,* are considered sufficient information to determine Medical Necessity; however, if documentation is lacking, the MCP must request additional supporting documents to substantiate Medical Necessity. *The Regional Center's determination of Medical Necessity stands for both initial authorizations and reauthorizations.*

MCPs must allow Members to stay in the same ICF/DD Home under continuity of care if the Member chooses to continue living in the ICF/DD Home and all of the following apply:

- The ICF/DD Home is licensed by CDPH;
- The ICF/DD Home is enrolled as a Medi-Cal Provider;
- The MCP will pay the ICF/DD Home payment rates that meet state statutory requirements;[39] and
- The ICF/DD Home meets the MCP's applicable professional standards and has no disqualifying quality-of-care issues.[40]

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[36] Form HS 231 is available at: *https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7F3DBDBF-4A2D-4779-AAEA-9EBA2873CBC6/hs_231.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.*
[37] 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=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.*
[38] The MCP ICF/DD Authorization Request *Form is available on the DHCS website as an attachment to this APL.*
[39] W&I section 14184.201(c).
[40] W&I section 14182.17.

Following their initial 12-month continuity of care period, Members or their authorized representatives may 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, or any superseding APL.

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, or any superseding APL. 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 the Member's right to request continuity of care, consistent with APL 23-022, or any superseding APL.

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 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 has 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 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.

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, or any superseding APL.

MCPs must also comply with the requirements in H&S section 1373.96 and W&I section 14186.3(c)(4).

V. Continuity of Care Requirements: Medi-Cal Covered Services for ICF/DD Home Residents with Existing Treatment Authorizations

Effective January 1, 2024, MCPs are responsible for TARs approved by DHCS, hereafter referred to as "authorization requests" for ICF/DD Home services provided under the ICF/DD Home per diem rate for the duration of the treatment authorization for existing authorization requests and for of up to two years for any new requests. [41]

MCPs are responsible for all other approved authorization requests 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.[42]

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[41] See the Medi-Cal Provider Manuals at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care.
[42] *H&S section 1367.01*

Effective January 1, 2024, ICF/DD Homes will continue to submit the Certification for Special Treatment Program Services form HS 231 to the MCPs with any initial 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. *An initial 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.*

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.[43, 44, 45, 46]

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.[47]

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 authorization request that includes the changed dates of service.

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[43] 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=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO* and *https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/EE176E40-D10D-4AC3-8F60-C72EE0AAC5CB/incont.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.*

[44] *The HS 231 form* can be found at: *https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7F3DBDBF-4A2D-4779-AAEA-9EBA2873CBC6/hs_231.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO*. *The MCP ICF/DD Authorization Request Form is available on the DHCS website as an attachment to this APL.*

[45] 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).

[46] W&I section 14131.10.

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

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 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).

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 Code of Federal Regulations (CFR) section 438.6(c) and is subject to future budgetary authorization and appropriation by the California Legislature.[48]

MCPs in counties where ICF/DD Home services benefit coverage is newly transitioning from the Medi-Cal FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2024,[49] 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, 2025, in accordance with W&I section 14184.201(c)(2), this APL, and the terms of the CMS-approved directed payment preprint.[50]

MCPs in counties where ICF/DD Home services are already Medi-Cal managed care Covered Services prior to January 1, 2024, 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, 2025, in accordance with W&I

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[48] The CFR is searchable at: https://www.ecfr.gov/.
[49] 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.
[50] 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.

section 14184.201(c)(2), this APL, and the terms of the CMS-approved state directed payment preprint as applicable.[51]

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 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 submit electronic claims and to 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.[52]

MCPs must pay timely in accordance with the prompt payment standards within their MCP Contract. MCPs must pay claims, or any portion of any claim, as soon as practicable but no later than 30 *calendar* days after receipt of the claim, and are subject to interest payments if failing to meet the standards.[53] MCPs must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 *calendar* days of receipt, and 99 percent of all clean claims from such practitioners' claims, within 90 *calendar* days of the date of receipt.[54] Please refer to APL 23-020, Requirements for Timely Payments of Claims, regarding

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[51] 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.
[52] Available at the DHCS CalAIM ICF/DD LTC Carve-In webpage.
[53] H&S section 1371.
[54] 42 CFR section 447.45(d)(2) and (d)(3).

requirements for MCPs related to timely payment of claims including Network Provider training requirements.

MCPs are highly encouraged to pay claims and invoices in the same frequency in which they are received, whether electronic or paper claims. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with this APL to a Network Provider of ICF/DD Home services, then MCPs must make such adjustments *as soon as practicable*, *but no later than 30 working days after the receipt of the claim by the MCP*.

MCPs must ensure that the Network Providers of ICF/DD Home services receive reimbursement in accordance with these 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.

VIII. 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 must 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 that will be implemented in a phased approach. TCS for high-risk Members was instituted January 1, 2023.[55] As of January 1, 2024, TCS will be required for all Members, regardless of risk status. By January 1, 2024, MCPs must ensure that 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.[56] 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.

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[55] 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.
[56] See the PHM Policy Guide, at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

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. 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 (POF) 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 basic PHM, TCS, and TCM 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 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 website[57]; the PHM Policy Guide[58]; APL 22-024, or any superseding APL; and the operative MCP Contract (as amended). For more information about ECM or Community Supports, please refer to the DHCS ECM and Community Supports webpage[59]; APL 21-012, or any superseding APL; APL 21-017, or any superseding APL; the Finalized ECM and

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[57] See the DHCS PHM Webpage, at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.
[58] See the PHM Policy Guide, at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf.
[59] See the ECM and Community Supports Webpage, at: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

Community Supports MCP Contract Template[60]; the ECM Policy Guide[61]; and the Community Supports Policy Guide.[62]

IX. 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 the California Department of Public Health (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.

X. Policies and Procedures

MCPs must update and submit their Policies and Procedures (P&Ps) to include all requirements in this APL to their Managed Care Operations Division (MCOD) Contract Manager. In addition, MCPs must submit any P&Ps required in any DHCS deliverables lists for LTC to their MCOD Contract Manager.

MCPs are further responsible for ensuring that their 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 and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any superseding APLs on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

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[60] See the ECM and Community Supports Template, at: https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf.
[61] See the ECM Policy Guide, at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.
[62] See the Community Supports Policy Guide, at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

XI. Long-Term Services and Supports Liaison

MCPs must identify an individual, or set of individuals, (either MCP or Subcontractor staff) to serve as liaisons for the Long-Term Services and Supports (LTSS) Provider community.[63] 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 rules. 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. MCPs must notify Network Providers of changes to LTSS liaison assignment expeditiously in order to ensure coordination and services offered to Members.

XII. *Credentialing*

DHCS will allow 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 Attestation[64] 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*

Re-credentialing 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 re-credentialed, an ICF/DD Home must report that

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[63] The requirement for the LTSS liaison is also outlined in APL 23-004.
[64] The ICF/DD Attestation is available on the DHCS website as an attachment to this APL.

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 will be 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.

XIII. **Additional Guidance**

ICF/DD Homes Provider Model Contract
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.[65] If the MCP's contract substantially deviates from these terms and conditions, MCPs are required to submit to DHCS for review and approval.

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.[66]

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[65] 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.
[66] 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.

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

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

ALL PLAN LETTER 23-023 ATTACHMENT A

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[67]
Health support, food and nutritional and pharmaceutical services[68]
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. - Examples include sensory motor development, self-help skills training, and

[67] 22 CCR sections 76907-76931.
[68] 22 CCR sections 76817-76906.

Included Services in ICF/DD Per Diem Rate
behavioral intervention programs
Transportation services when necessary for round trips to attending physicians[69]
Habilitation program which shall include recreation, education, and effective use of leisure time and socialization skills[70]
Early and periodic screening and diagnosis and treatment (EPSDT)[71]
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 beneficiaries 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)
Insulin
Intermittent positive pressure breathing equipment
Intravenous trays, tubing and blood infusion sets
Laboratory services (except as specified)
Legend drugs

[69] 22 CCR section 51343.1.
[70] 22 CCR section 51343.1(e).
[71] 22 CCR section 51340.

Excluded Services in ICF/DD Per Diem Rate
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 beneficiary
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[72]
Variable height beds
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.

[72] 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, or any superseding APL.

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.