Last Updated: October 25, 2024, Version 6

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

Introduction

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

Effective January 1, 2024, all MCPs are responsible for the full LTC benefit at the following facility types and homes[1]:

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

This transition applies to the following counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

The goal of the Medi-Cal LTC Carve-In is to provide better coordination across institutional and home and community-based settings as well as to make the LTC delivery system consistent across all counties in California. To support this transition, DHCS offered webinars for MCPs and providers, as well as implementation materials posted on the Intermediate Care Facility for Developmentally Disabled (ICF/DD) Long Term Care Carve-In website.

[1] ICF/DD-Continuous Nursing Care Homes are not subject to the LTC Carve-in policy.

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

Questions about CalAIM generally should be submitted to CalAIM@dhcs.ca.gov.

Contents

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

Benefits

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

   Please see the map and table provided below.

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

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

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

3. ***(Updated December 2023)*** **Which populations may be exempt from the ICF/DD LTC Carve-In?**

   Medi-Cal members residing in an ICF/DD Home in a non-COHS or non-Single Plan County may be exempt from mandatory managed care enrollment and can continue to receive coverage of ICF/DD services through Medi-Cal FFS if they meet one of following criteria:

   - Are an American Indian/Alaska Native;
   - Are a beneficiary who gets assistance under Foster Care, the Adoption Assistance Program, or Child Protective Services[2];
   - Already have an approved medical exemption from the requirement to join a Medi-Cal MCP; or
   - Get a medical exemption from the requirement to join a Medi-Cal MCP.

   If a member meets one of the criteria above, they have the choice to enroll in a Medi-Cal MCP or FFS Medi-Cal.

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

   SB 962 Homes are not included in the January 1, 2024 ICF/DD LTC Carve-In. The January 1, 2024 ICF/DD LTC Carve-In applies only to ICF/DD, ICF/DD-H, and ICF/DD-N Homes.

5. ***(Updated February 2024)*** **Are State-Operated Centers included in the ICF/DD Carve-in?**

   There are currently two state-operated facilities in California that have ICF/DD licenses and are funded by DDS – Canyon Springs Community Facility and Porterville Developmental Center (PDC). Medi-Cal members residing in both of these facilities are excluded from managed care enrollment and will receive coverage through Medi-Cal FFS.

[2] Foster care children and youth members who reside in Single Plan counties (Alameda, Contra Costa, and Imperial) have the choice to enroll in a Medi-Cal MCP or FFS Medi-Cal until January 1, 2025 per AB 118.

If a Medi-Cal member newly enters a state-operated facility on or after January 1, 2024, the state-operated facility can contact the DHCS Ombudsman at (888) 452-8609 or at MMCDOmbudsmanOffice@dhcs.ca.gov to disenroll the member from Medi-Cal managed care.

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

   A special indicator for the LTC transitioned population will be reflected on the Weekly Plan File starting November 30, 2023. The special indicator name is "LTC_2024". MCPs should use the claims data provided by DHCS to determine the facility type that the member resides in (see Question 2).

Billing and Payment

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

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

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

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

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

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

   Up to 12 diagnoses can be reported in the header on the Form CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic

claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.

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

10. ***(Updated February 2024)*** **Who should ICF/DD Home providers bill for services provided to members?**

ICF/DD Home providers should bill the payer currently responsible for covering the member. If an ICF/DD Home member is enrolled in an MCP, the ICF/DD Home provider should bill the MCP that the member is enrolled with. The MCP is responsible for covering all eligible Medi-Cal services, including ICF/DD Home services, for their members.

If a member changes their MCP, then the ICF/DD Home should continue to bill their previous MCP up until the member's enrollment change takes effect. Once the change takes effect, the ICF/DD Home should begin billing the member's new MCP. The date of service should align with the member's MCP enrollment effective dates.

If an ICF/DD Home member receives coverage through Medi-Cal FFS due to a managed care exemption or their plan selection has not yet gone into effect, then the ICF/DD Home should bill Medi-Cal FFS.

11. ***(Updated February 2024)*** **How can ICF/DD Home providers determine who to bill for ICF/DD Home services?**

To determine who to bill for ICF/DD Home services, ICF/DD Home providers can check a member's Medi-Cal eligibility record via the Automated Eligibility Verification System (AEVS), which is accessible through the DHCS Provider Portal. The member's Medi-Cal eligibility record will identify which Medi-Cal Managed Care Plan (MCP) a member is enrolled in or indicate if the member is presently in Medi-Cal Fee-for-Service (FFS). If AEVS indicates FFS, ICF/DD Home providers should bill Medi-Cal FFS for services provided to that member. If AEVS lists a specific MCP, ICF/DD Home providers should bill that MCP.

12. (***Updated October 2024)*** **When the FFS per diem rate is updated, when can ICF/DD Home providers expect to receive payment based on the updated rate?**

    The Medi-Cal FFS per diem rate remains effective until an updated per diem rate is published. When an updated per diem rate is published, MCPs must begin making payments based on this rate for all claims on or after the applicable date of service, within 30 Working Days of being notified by DHCS. The transition to the updated per diem rate may result in revised payments owed to ICF/DD Home providers, retroactively. MCPs are responsible for adjusting claims retroactively and issuing correct payments to ICF/DD Home providers within 45 Working Days after being notified of the published updated rate. MCPs must not require ICF/DD Home providers to resubmit claims as a result of the published updated per diem rate.

13. ***(Updated December 2023)*** **How do providers bill MCPs for excluded services, such as professional and ancillary services that are not included in the ICF/DD per diem?**

    Excluded services that are MCP-covered and not included in the ICF/DD per diem should be billed to the MCP separately. Included and excluded services are listed in Attachment A of APL 24-011. Rates for excluded services are negotiated between the MCP and provider. These services and supplies are subject to the general provisions and billing limitations set forth in state regulation 22 CCR § 51303 and 51304.

14. ***(Updated October 2024)*** **Will ICF/DD Home providers be able to bill and get paid by MCPs while they are working to establish a contract?**

    Under Continuity of Care, ICF/DD Home providers will be able to bill MCPs and receive per diem rates while establishing a contract and undergoing credentialing. However, Homes may need to complete a Letter of Agreement with the MCP and/or submit the initial documentation to MCPs, as listed in Section XII – Credentialing of APL 24-011, to receive payments. The initial documentation provides MCPs with the relevant business information they need to create their claims payment profile for ICF/DD Homes.

    Payment processes, including timely payment of claims, requirements for Network Providers also apply for Out-of-Network Providers when those dates of service were under continuity of care.

15. ***(Updated December 2023)*** **Will billing codes be standard across all MCPs?**

    The Billing and Invoice Guidance document defines the necessary data elements that MCPs must use in order to minimize burden and create standardized invoicing/claiming processes for ICF/DD Home providers.

Please note that effective February 1, 2024, DHCS is transitioning to National Uniform Billing Committee (NUBC) Health Insurance Portability and Accountability Act (HIPAA)-compliant code set and national claim form for Medi-Cal FFS to provide administrative simplification and ease of use. More information about the conversion can be found on the DHCS LTC Claim Form and Code Conversion webpage. Because MCPs are not required to align billing codes with Medi-Cal FFS, providers are encouraged to validate billing codes with MCPs before they begin billing to ensure the appropriate codes are being utilized to produce a clean claim. ICF/DD Homes may reach out to the MCPs' LTSS Liaisons with questions or for assistance in the billing process.

16. ***(Updated December 2023)*** **Will providers be able to do testing of electronic claims submission prior to January 1, 2024?**

MCPs must educate and train their Network Providers on their billing, invoicing, and clean claims submission protocols, including having resources available for providers' reference. While not required, DHCS encourages MCPs to offer ICF/DD Home providers the opportunity to test claims submissions. ICF/DD Homes should contact the LTSS liaison(s) of the MCP(s) they are contracting with to learn more about the MCPs' billing resources and trainings.

17. ***(Updated October 2024)*** **Are Regional Centers providing payment assistance to ICF/DD Home providers during the ICF/DD Carve-In transition?**

Yes, Regional Centers are providing payment assistance, also referred to as lag funding, for ICF/DD Home providers if they experience delays in receiving reimbursement from MCPs during the initial transition of the DHCS ICF/DD Carve-In. The lag funding will temporarily provide payment to ICF/DD Home providers until MCP payments are received. Upon receipt of MCP payments, ICF/DD Homes must repay lag funding to the Regional Center. To request lag funding, ICF/DD Homes providers must attest to either of the following:

- Claims have been submitted to the MCP and have not been reimbursed within 30 days OR,
- Due to factors beyond the ICF/DD Home provider's control, the provider has been unable to submit, or been delayed in the submission of, claims to the MCP for services provided at least 30 days prior to the request for lag funding.

More details on the lag funding can be found on the DDS Regional Center Directive website and at the links below:

- DDS Regional Center Directive – "Payment Assistance for Intermediate Care Facilities During the Transition to Managed Care"
- 1/30/24 Email Update

- 10/3/24 Update - Intermediate Care Facilities Lag Funding
- Lag Funding Agreement
- Lag Payment Attestation Form

18. ***(Updated April 2024)*** **What data fields are MCPs required to include in remittance advice?**

    MCPs must include, at minimum, the data fields detailed in the Medi-Cal Provider Manual in the remittance advice provided to ICF/DD Home providers, ***except for the following fields***:

    - Item 3 – Claim Control Number
    - Item 12 – Rate
    - Item 17 – FI Sequence Number

    All other data fields in the remittance advice are required for ICF/DD Home auditing and cost reporting purposes.

Authorizations

19. ***(Updated October 2024)*** **What is the expected turn-around time for routine authorizations, such as when a member is transitioning from a Skilled Nursing Facility or from the community to an ICF/DD Home?**

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

20. ***(Updated December 2023)*** **Are MCPs required to use the new MCP ICF/DD Authorization Request form, or are they able use a plan-specific authorization request form?**

    MCPs are not required to use the new MCP ICF/DD Authorization Request form and may use a plan-specific authorization request form. However, if an MCP chooses to use a plan-specific authorization request form, it must only include the MCP ICF/DD Authorization form provided data elements. It cannot require additional data elements beyond the ones listed on the MCP ICF/DD Authorization Request form.

21. ***(Updated December 2023)*** **Are MCPs able to authorize ICF/DD services for less than two years?**

    MCPs are responsible for approving any new treatment authorization and reauthorization requests for ICF/DD Home services for up to two years, in alignment with the current authorization/reauthorization policy for ICF/DD Home services as documented in the Medi-Cal Provider Manual and established in regulations. MCPs are responsible for ensuring members receive all necessary services and supports. Therefore, MCPs may reauthorize services more frequently than two years on a case-by-case basis based on an individual member's needs and circumstances.

22. ***(Updated February 2024)*** **Are MCPs able to extend TARs that have expired?**

    MCPs may extend existing, DHCS-approved TARs that were set to expire in early 2024 to help facilitate a smooth transition of services for members. Since MCPs verify that the dates of service on the claim match the authorization approval time period, extending existing TARs should not affect a provider's claim submission or timely payments.

Complaint Resolution

23. **How will member complaint resolution be handled?**

    All MCPs are required to maintain an appeals and grievances process that is accessible to members and provide a Notice of Action (NOA) to members any time a requested service is denied, modified, or reduced. All MCPs have an appeals and grievances process related to service authorization denials for which the MCP is responsible. See APL 21-011.

Continuity Of Care

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

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

    Post January 1, 2024 implementation, MCPs will receive TAR and Plan Data Feed data for members new to their MCP or transitioning between MCPs on a monthly basis. The Plan Data Feed provides 12 months of historical utilization

data to the MCPs on a monthly basis. Data includes paid pharmacy, dental, specialty mental health, FFS medical claims, and encounters from other MCPs.

25. *(Updated October 2023)* When should ICF/DD Home members begin to make their MCP selections?

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

26. *(Updated December 2023)* What does automatic Continuity of Care apply to?

Automatic Continuity of Care only applies to 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 member's transition to the MCP.

For Continuity of Care beyond ICF/DD Home placement, members with conditions specified in H&S Section 1373.96 may request to continue care with any provider type. To access Continuity of Care for providers, a request may be made to the MCP prior to the date of service. Continuity of Care also provides continued access to the following services but may require a switch to in-Network Providers: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), professional services, and select ancillary services.

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. While Continuity of Care is automatic for ICF/DD Home placement for the first 12 months after a member transitions into an MCP, a member can request an additional 12 months of Continuity of Care if the member chooses to continue living in the ICF/DD Home.

27. ***(Updated February 2024)*** **Does Continuity of Care apply to Durable Medical Equipment (DME) and medical supplies?**

    Yes, Medi-Cal MCPs must allow transitioning Members to keep their existing DME rentals and medical supplies from their existing Provider, under the previous Prior Authorization for a minimum of 90 days following MCP enrollment and until the new MCP is able to reassess, the new equipment or supplies are in possession of the Member, and ready for use. Continuity of DME and medical supplies must be honored without a request by the Member, authorized representative, or Provider. After 90 days, the MCP may reassess the Member's authorization at any time and require the Member to switch to a Network DME Provider. Further details are available in the Continuity of Care APL 23-022.

28. ***(Updated December 2023)*** **How do members request Continuity of Care?**

    If a member would like to access Continuity of Care, the member, their authorized representative, or their provider may request Continuity of Care by calling their new MCP and providing the required information to them over the phone.

Member Communications and Enrollment

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

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

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

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

31. ***(Updated October 2023)*** **When do ICF/DD Home members need to enroll into a Medi-Cal MCP before DHCS assigns them into an MCP?**

    When a member has more than one plan option, the member will need to choose an MCP by the date listed in their "My Medi-Cal Choice Packet", which will be mailed to eligible members beginning November 3, 2023, or they will be automatically enrolled in an MCP. Additionally, members will receive Enrollment Notices 60 days and 30 days before January 1, 2024, which will include the MCP

they will be enrolled in if they do not choose one by the date listed in their "My Medi-Cal Choice Packet".

32. *(Updated October 2023)* How often may an ICF/DD Home member change their MCP?

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

33. *(Updated December 2023)* Who can help ICF/DD Home member with Medi-Cal eligibility matters (e.g., applications or renewals)?

Individuals who are competent can either use form MC 382 or the single streamlined Medi-Cal application (at the point they are applying for Medi-Cal) to appoint an authorized representative.

For individuals who are unable to act for themselves, counties have a process to determine if there is someone who can act for them for the purposes of Medi-Cal eligibility based on hierarchy, such as a spouse, guardian, conservator, or person with legal authority like a Power of Attorney (POA). Per All County Welfare Directors Letter (ACWDL) 94-62, anyone who knows of an applicant's need to apply can submit an application for the purpose of preserving the date of application for Medi-Cal. However, only certain individuals/entities can provide the necessary information to determine eligibility and act on behalf of an individual who cannot act for themselves.

An ICF/DD Home can act on the resident's behalf if there is no spouse, conservator, guardian or executor and the applicant is not considered competent. In order to assist a resident with Medi-Cal applications or renewals, an ICF/DD Home would need to contact their local county office. They can inform the county office of the applicant's known circumstances and that the Home is willing to act on behalf of the applicant who is not competent if there is no spouse, conservator, guardian or executor, per the guidance in ACWDL 94-62. Contact information for county offices is available on the DHCS County Offices webpage.

Additionally, Medi-Cal Eligibility Procedures Manual (MEPM) 19 provides that Regional Centers may act on an applicant's behalf if they cannot act for themselves, or the individual's financially responsible family member can act on their behalf. It also allows counties to share ongoing eligibility information with the

Regional Centers regardless of who acts on the client's behalf. There is no requirement that Regional Centers provide a form such as the MC 382 to collaborate with counties or act for a member who can't act for themselves. DDS has corresponding guidance, as documented in the HCBS Waiver Primer and Policy Manual, stating Regional Centers are authorized to apply for Medi-Cal on behalf of their adult consumers who do not have a legal guardian or conservator.

Applicants/members who cannot act for themselves shall **not** be denied or discontinued solely for the reason that there is no entity assigned to act for them.

34. (*Updated December 2023)* Who can help ICF/DD Home member with MCP enrollment?

For purposes of member enrollment into a MCP, Medi-Cal Health Care Options (HCO) can provide enrollment assistance to members or other representatives over the phone. Medi-Cal HCO has a process in place whereby someone who is not a member's legal representative (such as a conservator or an authorized representative) can still assist a member in enrolling in an MCP. This process will allow an Enrollment Assistant, which may include Regional Center staff or ICF/DD Home providers, to make an enrollment choice on behalf of a member. Individuals acting as Enrollment Assistants will need to go through this process every time they want to make an enrollment choice on behalf of the beneficiary. This process cannot be used for any other actions or to make medical decisions on behalf of the member. This information will be clearly explained to the Enrollment Assistant.

HCO can be contacted at 1 (800) 430-4263. Enrollment can be done over the phone when talking to a Customer Services Representative, online, by mailing in a Choice Form or in person by visiting a Field Operations site. See Enroll | Medi-Cal Managed Care Health Care Options.

35. *(Updated October 2023)* How can an individual update their Authorized Representative?

If a member needs to have an Authorized Representative added to their case and the member is a Social Security beneficiary, they must reach out to their local Social Security office to add their Authorized Representative. If the member is not a Social Security beneficiary, they must reach out to their local county office to add/update the individual or organization appointed their Authorized Representative. In some cases due to system limitations, individuals appointed as Authorized Representative through their local county office may not be reflected in Medi-Cal Eligibility Data System (MEDS).

Notices are posted on the ICF/DD Carve-In Member information webpage, and links to the notices will be provided to the facilities so that they can access them

as well. All members and their Authorized Representatives can access the notices located online.

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

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

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

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

38. ***(Updated February 2024)*** **What should an ICF/DD Home member do if they were not able to enroll in an MCP due to a mismatch in their zip code and county code in MEDS?**

    When a Medi-Cal member's zip code and county code do not match in MEDS, the member may not be able to enroll into an MCP. The member or the person authorized to make changes on their eligibility case needs to contact the Local County Office to make any necessary updates to the member's address.

    If the member has submitted their plan enrollment choice with Health Care Options, DHCS will hold their plan choice for 90 days to allow the member or the person authorized to make changes on their eligibility case the time to work with the county to make the necessary updates. Once the update is made, DHCS will process the member's plan choice as appropriate.

    The member will remain in Medi-Cal FFS until their address has been updated.

39. ***(Updated April 2024)*** **Who can an ICF/DD Home provider contact with questions or concerns regarding an ICF/DD Home member's MCP enrollment?**

    For questions or concerns regarding an ICF/DD Home's member MCP enrollment, DHCS can help. Please follow the instructions below to send the specific case information to DHCS:

    - Please email PCUResearch@dhcs.ca.gov, **using the subject line: LTC Enrollment Concern: "Add Facility Name"**
    - Include a description of the concern or issue you are experiencing specific to enrollment into a managed care plan.

- Do **not** include member specific details like Client Index Number (CIN), Date of Birth, First Name and Last Name.
- DHCS staff will respond to your initial email with a secure (protected) email requesting these member specific details. Providing these details will assist DHCS in researching the member's status.
- DHCS will provide a response once research has been completed.

40. (*Updated April 2024)* What is the process for transitioning a member to an ICF/DD Home in another county?

When moving to a new county, the member or their authorized representative is responsible for notifying either the county from which they are moving from or the county to which they are moving to of the change in residence. More information on the Medi-Cal inter-county transfer process can be found in the All County Welfare Directors Letter (ACWDL) 18-02E. There are certain circumstances in which a Regional Center and/or ICF/DD Home may act on a member's behalf for eligibility related matters, which are detailed in the Member Communications and Enrollment section above.

Once the member moves and is enrolled in their new MCP, the new ICF/DD Home will be responsible for submitting an authorization request to the member's new MCP. If the member is also transitioning to a new Regional Center catchment area, the current/old Regional Center and the new Regional Center are required to conduct pre-transfer planning to coordinate the transition of individual program plan (IPP) services and supports.

When a member is transitioning from one ICF/DD Home to another, the current MCP is responsible for providing Transitional Care Services to the member, as detailed in the DHCS Population Heath Management Policy Guide. The MCP should coordinate with the Regional Center on the transition of the member's services-based care coordination policies and procedures defined in the MOU with the Regional Center (please refer to APL 23-029 and the Regional Center Memorandum of Understanding Template).

To help facilitate a smooth transition for the member, DHCS would encourage MCPs to conduct a warm handoff and/or case conference with key staff from all involved entities, which could include:

- MCP case manager (old/current)
- MCP case manager or contact (new)
- Regional Center representative (old/current)
- Regional Center representative (new)
- ICF/DD Home representative (old/current)
- ICF/DD Home representative (new)

Contracts

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

To find the list of MCPs serving each county effective January 1, 2024, please visit the DHCS Medi-Cal MCP Look-up tool.

42. *(Updated December 2023)* Will contracted ICF/DD Home providers be listed in the MCP's Provider Directory?

In accordance with 42 CFR § 438.10(h)(1 – 2), MCPs must make the following information available within their Provider Directories for physicians, including specialists, hospital, pharmacies, behavioral health providers, and LTSS providers, as appropriate (including ICF/DD Homes):

- The provider's name as well as any group affiliation.
- Street address(es).
- Telephone number(s).
- Web site URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider will accept new enrollees.
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

43. *(Updated February 2024)* What should an ICF/DD Home do if a member enrolls in an MCP that the ICF/DD Home is not contracted with?

ICF/DD Homes should get in contact with their member's assigned MCP as soon as possible to begin the contracting process.

While this process is under way, 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. Under Continuity of Care, ICF/DD Home providers will be able to bill MCPs and receive per diem rates while establishing a contract and undergoing credentialing. However, ICF/DD Homes may need to complete a Letter of Agreement with the MCP and/or submit the business information that the MCPs need to create claims payment profiles for ICF/DD Homes in order to receive payments.

If the ICF/DD Home is not yet contracted with the MCP at the end of the initial 12-month Continuity of Care period, the member, their Authorized

Representative, or the provider may contact the MCP to request an additional 12 months of Continuity of Care.

44. *(Updated April 2024)* Are MCPs required to provide provider portal access to providers to view the status of claims, authorizations, and referrals while they are completing the contracting process?

MCPs are not required to provide portal access to non-contracted providers. However, if non-contracted providers are not granted portal access, MCPs must ensure providers have access to the information they need to support access to care under Continuity of Care through other mechanisms. While MCPs vary in their use of provider portals, some MCPs allow non-contracted to access their provider portals. ICF/DD Home providers are encouraged to contact the MCPs they are working with to confirm if portal access is available while undergoing contracting.

45. *(Updated October 2024)* While undergoing a change of ownership, what verification does an ICF/DD Home need to submit in order to contract with an MCP?

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 may accept either of the following documents as sufficient verification that the ICF/DD Home is undergoing a change of ownership for the purposes of contracting with an MCP:

- A copy of the signed management agreement between the incoming and previous owner
- A copy of the application approval letter provided by the California Department of Public Health

Credentialing

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

Yes, an ICF/DD Home will still be able to be reimbursed beginning January 1, 2024, while undergoing credentialing. However, ICF/DD Homes may need to complete a Letter of Agreement with the MCP and/or submit initial documentation in order to receive payments. The initial documentation consists of a W-9 Request for Taxpayer Identification Number and Certification, an MCP Ancillary Facility Network Provider Application, Certificates of Insurance (Professional and General Liability), a City or County Business License (excluding ICF/DD-H and -N Homes with six [6] or less residents), and Ownership Disclosure. This initial

documentation provides MCPs with the relevant business information they need to create the claims payment profile for an ICF/DD Home.

47. ***(Updated December 2023)*** **How often does credentialing need to be completed?**

    To complete the initial credentialing process, ICF/DD Homes must submit the following documents and 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

    Re-credentialing is to occur every two years thereafter through re-submission of an ICF/DD Attestation.

48. ***(Updated December 2023)*** **Do the initial credentialing documents need to be submitted when an ICF/DD Home is re-credentialed?**

    Initial documents required for credentialing of an ICF/DD Home do not need to be re-submitted for re-credentialling. Only the attestation form is to be used for biannual re-credentialling.

49. ***(Updated December 2023)*** **Does the MCP-specific provider training need to be completed by the ICF/DD Home provider for their initial credentialing at the time they are submitting the attestation form?**

    The MCP-specific provider trainings needs to be completed within the first 30 days of the provider being contracted with the MCP.

50. ***(Updated October 2024)*** **Can MCPs request additional documents when credentialing ICF/DD Home providers (e.g., copies of their completed site audit), in addition to the documents listed in the APL 24-011?**

    MCPs may not require additional documentation for ICF/DD credentialing outside of the documents listed in APL 24-011. MCPs may request further documentation outside of the credentialing process, such as when they are conducting their own audits. However, such documentation should not be an additional required document for credentialing.

51. ***(Updated December 2023)*** **What types of site visits do MCPs need to accept in order to credential ICF/DD Home providers?**

    The Centers for Medicare & Medicaid Services (CMS) Survey is the site visit that is acceptable for credentialing ICF/DD providers.

52. *(Updated December 2023)* If an ICF/DD Home has not gone through the Regional Center vendorization process, can they still attest to being in good standing with the Regional Center vendor?

Some ICF/DD Homes may be in good standing with the Regional Center but are not vendored. ICF/DD Homes that have not gone through the vendorization process can attest that they have received referrals for the possible placement of individuals in the Home or that they are already providing services to individuals.

Share of Cost

53. *(Updated October 2023)* Who is responsible for collecting the member's Share of Cost (SOC)?

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

54. *(Updated October 2024)* If a member has a Share of Cost, what are the ICF/DD Home's recordkeeping responsibilities?

ICF/DD Homes are responsible for collecting SOC from members if SOC is indicated in the Medi-Cal eligibility verification system. ICF/DD Homes are also responsible for reporting the collection of SOC to MCPs on claims submitted for those members. Pursuant to the Johnson v. Rank lawsuit, a member may spend part of their Share of Cost on medically necessary services, supplies, or equipment not covered by Medi-Cal. The ICF/DD Home will need to subtract those amounts from a member's Share of Cost and collect the remaining Share of Cost amount owned. The expenditures from member's Share of Cost funds must be recorded on the Record of Non-Covered Services (DHS 6114 form). Please refer to the Share of Cost: UB-04 for LTC section of the Medi-Cal Provider Manual for more information and a sample completed DHS 6114 form.

LTSS Liaison

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

MCPs must identify an individual, or set of individuals, (either MCP or Subcontractor staff) to serve as liaisons for the LTSS Provider community. The LTSS liaison is not required to be credentialed/licensed but must have the ability to support the ICF/DD population's service needs. These staff must be trained by the MCP to identify and understand the full spectrum of Medi-Cal LTC, including

payment and coverage rules. LTSS liaisons must serve as a single point of contact for service providers in a Provider representative role. LTSS liaisons may also work with transitional care services staff to support care transitions, as needed. LTSS liaisons must assist service providers in addressing claims and payment inquiries in a responsive manner and assist with care transitions among the LTSS Provider community to best support a member's needs. LTSS liaisons do not have to be a clinical licensed professional but may be fulfilled with a non--licensed or paraprofessional.

Once MCPs have identified their LTSS liaisons, MCPs must disseminate their contact information to their Network Providers. MCPs must also notify Network Providers of changes to contracted MCPs' LTSS liaison assignment expeditiously in order to ensure coordination and services offered to members.

Leaves of Absences and Bed Holds

56. *(Updated April 2024)* Are authorizations required for Leaves of Absence and Bed Holds?

Bed hold orders are required to be signed by a physician. For leaves of absence, MCPs are encouraged to follow but must not be more stringent than the Medi-Cal Provider Manual. This includes not requiring readmission authorizations for members returning from a leave of absence if a valid authorization covers the return date, and the member's records must show the address of the intended leave destination and inclusive dates of leave. This means that MCPs cannot require authorizations for leaves of absences and should track leaves of absences through billing codes. However, a physician signature is required for a leave of absence only when a member is participating in a summer camp for the developmentally disabled, in accordance with the Medi-Cal Provider Manual.

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

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

Medical Necessity

58. What documentation will the MCP use to determine Medical Necessity?

Medical Necessity is determined by the Regional Center using documentation reflecting current care needs and the member's prognosis. ICF/DD Homes will send the HS231, DHCS 6013A, and MCP ICF/DD Authorization Request Form to the MCP as proof of Medical Necessity. ICF/DD-N Homes will send an Individual

Service Plan (ISP) with re-authorizations. If documentation is lacking, the MCP can request additional supporting documents to substantiate medical necessity.

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

MCPs are to utilize the HS 231 (Certification for Special Treatment Program Services) form and the DHCS 6013 A (Medical Review/Prolonged Care Assessment) form **or** the information found on the DHCS 6013 form in any format (e.g., a copy of the Individual Program Plan [IPP] or Individual Service Plan [ISP]).

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

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

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

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

Dental

62. ***(Updated October 2023)*** **How will the ICF/DD LTC Carve-In transition affect dental care for members?**

The ICF/DD Carve-In to managed care will not affect how dental care is provided to members. Members will continue to receive the same dental services from the

same delivery system as they do today, either through FFS or Dental Managed Care in the following counties: Sacramento and Los Angeles.

Oversight and Quality Assurance

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

The survey findings are posted in the CDPH California Health Facilities Information Database. Results can be found for each facility reviewed in a search by the individual facility.

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

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

Regional Centers

65. *(Updated December 2023)* Do Regional Centers have a Regional Center Directive, similar to *APL 24-011*?

Yes, the Department of Developmental Services (DDS) issued a directive to Regional Centers with details of the Carve-In. The directive, titled Intermediate Care Facility for Developmentally Disabled Transition to Managed Care, is available on the DDS Regional Center Directives webpage.

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

Yes, case management will continue to be a function of the Regional Center, including coordinating with the MCP for the provision of Early and Periodic Screening, Diagnostic, and Treatment for eligible populations.

MCPs are required to coordinate and work with Regional Centers in the identification of services that will be provided to the members by the MCP. The goal is to reduce any duplication of effort or work among the MCPs and Regional

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

67. ***(Updated December 2023)*** **How will MCPs be informed about the designees for the Regional Center Director/Local Mental Health Director who may determine requests for services made on the Certification for Special Treatment Program Services (HS 231) form?**

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

68. ***(Updated December 2023)*** **Upon Regional Center Director/Local Mental Health Director determination, will the Regional Center Director/Local Mental Health Director forward their decision to the MCP?**

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

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

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

70. ***(Updated October 2023)*** **Is the Regional Center Director/Local Mental Health Director responsible for sending approval and denial Notice of Action (NOA) letters?**

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

71. **Is the new policy of procedures for the Regional Center Director/Local Mental Health Director determination that the Regional Center Director/ Local Mental Health Director would forward the decision to the MCP?**

    No, staff of the ICF/DD Home are responsible for sending the approvals/denial NOA letters to the MCPs. However, it is the responsibility of either the Regional

Center Director or the Local Mental Health Director of the ICF/DD Home to authorize the approval or deny the request for services.

72. *(Updated December 2023)* Do Regional Centers have dedicated liaisons that can assist ICF/DD Homes and MCPs throughout the Carve-In transition?

Yes, Regional Centers have dedicated liaisons that can assist ICF/DD Homes and MCPs throughout the ICF/DD Carve-In transition. A full list of Regional Center ICF/DD Transition Contacts is available through HealthFacilities@dds.ca.gov.

Transportation

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

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

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender. MCPs are required to provide medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT services are required for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. MCPs must also have processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

At minimum, MCPs must provide the lowest cost type of NEMT service that is adequate for the member's medical needs, as determined by the medical professional. MCPs must ensure that there are no limits to receiving NEMT as long as the member's services are medically necessary, and the member has

prior authorization for the NEMT. For Medi-Cal services that are not covered under the MCP contract, MCPs must make their best effort to refer and coordinate NEMT services. However, MCPs must provide medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

For more information, please see APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

Prime and Delegate MCPs

74. *(Updated February 2024)* What are Delegated Subcontractor MCPs?

In Los Angeles County, certain MCPs, referred to as Prime Plans, partner with other MCPs, referred to as Delegate Subcontractors, to help members get the care they need. For example, LA Care is a Prime Plan and partners with Anthem and Blue Shield Promise as Delegate Subcontractors. Health Net also serves as a Prime Plan and partners with Molina as a Delegate Subcontractor.

If a member is enrolled in a Delegate Subcontractor, the Delegate Subcontractor is responsible for covering eligible Medi-Cal services, including ICF/DD Home services, for that member.

75. *(Updated February 2024)* How can ICF/DD Home providers determine if a member was enrolled in a Prime Plan or a Delegate Subcontractor plan?

Providers can determine which MCP their members are enrolled in by checking the members' eligibility record via AEVS, which is accessible through the DHCS Provider Portal. Providers can also check if a member is assigned to a Delegated Subcontractor by checking the member's eligibility in the Prime Plan's provider portal, or by checking the member's health plan ID card.

76. *(Updated February 2024)* If a member is enrolled in a Delegated Subcontractor plan, does the ICF/DD Home provider need to contract with the Delegated Subcontractor plan?

Yes, if a member is enrolled in a Delegated Subcontractor plan, the ICF/DD Home will need to contract with that plan.

Under Continuity of Care, ICF/DD Home providers are able to bill MCPs and receive per diem rates while establishing a contract and undergoing credentialing. However, ICF/DD Homes may need to complete a Letter of Agreement with the MCP and/or submit the business information that the MCP needs to create claims payment profiles for ICF/DD Homes in order to receive payments.

77. ***(Updated February 2024)*** **If a member is enrolled in a Delegated Subcontractor plan, which plan should the provider bill?**

    If the member is enrolled in a Delegated Subcontractor plan, the ICF/DD Home provider should bill the Delegated Subcontractor plan.

78. ***(Updated February 2024)*** **How can a member switch their enrollment from a Delegated Subcontractor plan to a Prime Plan, or from a Prime Plan to Delegated Subcontractor?**

    The member or their representative can contact the Prime Plan for any of the following scenarios:

    - If they would like to be re-assigned to a Delegated Subcontractor;
    - If they are assigned to a Delegated Subcontractor and would like to be re-assigned to the Prime Plan; or
    - If the member is assigned to a Delegated Subcontractor and would like to be re-assigned to another Delegated Subcontractor under the same Prime Plan.