ICF/DD Carve-In Stakeholder Workgroup

Tenth Session

Monday July 24, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Workgroup Agenda

- Introductions
- Deliverable Updates
- Vignettes: Process Flows for ICF/DD Home Members

How to Add Your Organization to Your Zoom Name

- Click on the **Participants** icon at the bottom of the window.
- Hover over your name in the **Participants** list on the right side of the Zoom window.
- Select **Rename** from the drop-down menu.
- Enter your **name** and add your **organization** as you would like it to appear.
- For example: Kevin Tolmich – Mercer

ICF/DD Carve-In Workgroup

- Meetings are open to the public using the link from the LTC ICF/DD web page: Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In
- Presentations and discussion are welcome from all Workgroup members and all other attendees.
- Members of the public will remain in listen-only mode. Any member of the public may send an email regarding questions or comments they may wish to share for DHCS/DDS consideration: ICFDDworkgroup@dhcs.ca.gov
- Workgroup meetings will be a solution-focused, collegial environment for respectfully expressing different points of view.
- Workgroup is for direct communication and problem solving with the DHCS for the ICF/DD carve-in to Medi-Cal managed care.

Roll Call: ICF/DD Workgroup Members

Name	Organization
Janet Davidson	Health Plan of San Mateo
Dennis Mattson	Independent Options
Brian Tremain	Inland Regional Center
Becky Joseph	JonBec Care Inc.
Linnea Koopmans	Local Health Plans of California
Jenn Lopez	Local Health Plans of California
Lori Anderson	Momentum
Stacy Sullivan	Mountain Shadows Support Group
Larry Landauer	Regional Center of Orange County
Mark Klaus	San Diego Regional Center
Olivia Funaro	San Gabriel/Pomona Regional Center
Tiffany Whiten	Service Employees International Union
Matt Mourer	The Arc of SD
Deb Donovan	Valley Village

Roll Call: ICF/DD Workgroup Members

Name	Organization
Kim Mills	A Better Life
Beau Hennemann	Anthem
Amy Westling	Association of Regional Center Agencies
Susan Mahonga	Blue Shield of California
Ysobel Smith	Blue Shield of California
Craig Cornett	California Association of Health Facilities
Jennifer Breen	California Association of Health Facilities
Scott Robinson	CalOptima
Tami Reid	CenCal
Sylvia Yee	Consumer Voice
Kathy Mossburg	Developmental Services Network
Diane VanMaren	Developmental Services Network
Elizabeth Zirker	Disability Rights California
Edward Mariscal	HealthNet

Introductions: DHCS

DHCS

Susan Philip, Deputy Director, HCDS

Bambi Cisneros, Assistant Deputy Director, Managed Care, HCDS

Beau Bouchard, Assistant Division Chief, CRDD

Stephanie Conde, Branch Chief, MCOD

Tyra Taylor, Assistant Chief, CAD

Shanell White, Branch Chief, CAD

Dana Durham, Division Chief, MCQMD

Stacy Nguyen, Branch Chief, MCQMD

Adrienne McGreevy, MCQMD Section Chief

Alek Klimek, Chief, FFSRDD

Rafael Davtian, Deputy Director, HCF

Michelle Retke, Division Chief, MCOD

Jesse Delis, Assistant Division Chief, CRDD

Christie Hansen, LTC Rates Section Chief FFSRDD

Phi Long (Phil) Nguyen, Research Data Supervisor, FFSRDD

Tracy Meeker, Consultant, MCQMD

Jalal Haddad, Project Manager, HCDS

Introductions: DHCS

DDS

Jim Knight, California Department of Developmental Services

Caroline Castaneda, California Department of Developmental Services

Jane Ogle, Consultant for California Department of Developmental Services

Consultants

Kathy Nichols, Mercer

Brittany van der Salm, Mercer

Kayla Whaley, Mercer

Kevin Tolmich, Mercer

Branch McNeal, Mercer

Kristal Vardaman, Aurrera Health Group

Becky Normile, Aurrera Health Group

Brendan Finn, Aurrera Health Group

Winter Koifman, Aurrera Health Group

Workgroup Charge and Goals

- To provide an opportunity for stakeholders to collaborate and provide advisory feedback on DHCS' policy and operational efforts in carving in ICF/DD homes from FFS into Medi-Cal managed care.
- The ICF/DD Workgroup will focus on issues specific to Medi-Cal beneficiaries with developmental disabilities, and the ICF/DD homes and providers who serve this population.
- The goal of the workgroup will be to create an ICF/DD Promising Practices/FAQ document, which DHCS may use to inform development of an APL focused on the ICF/DD carve-in.

Deliverables Updates

- Accommodation Code Conversion update
- APL
  - 203 comments were received
- Model Contract Language
- Billing and Invoice Guide
- Credentialing
- Member-Friendly Fact Sheet
- ICF/DD Homes Key Contacts List
- Notice to Regional Centers

Process Flows for ICF/DD Home Members

ICF/DD Facility/Home Types

ICF/DD

"Intermediate care facility/developmentally disabled" is a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

ICF/DD-H

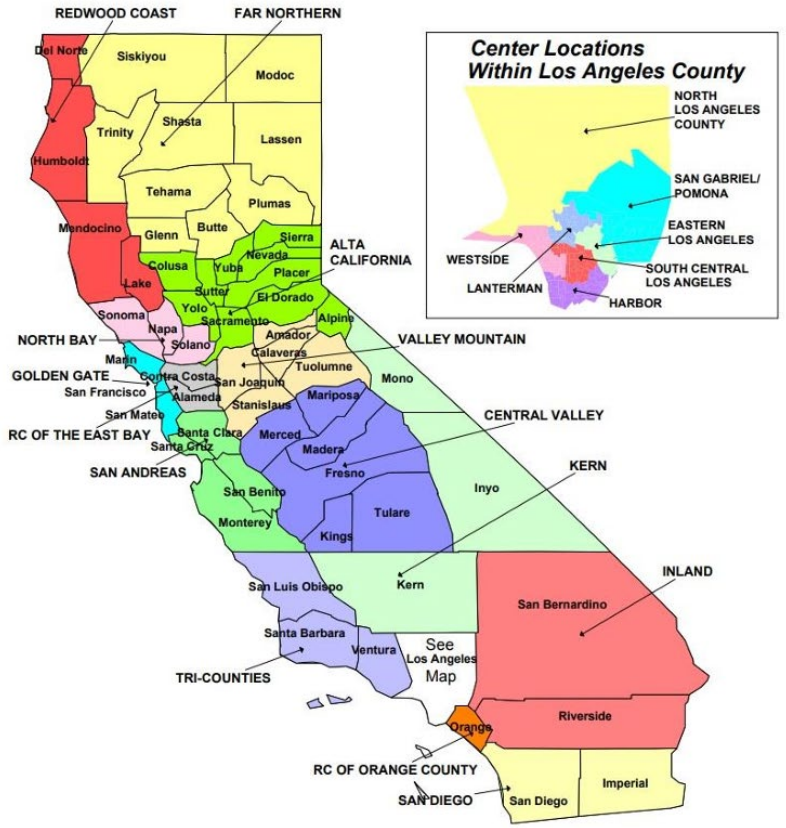
Intermediate care facility/developmentally disabled-habilitative" is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

ICF/DD-N

Intermediate care facility/developmentally disabled-nursing" is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

Regional Centers in a Nutshell

- 21 regional centers with distinct geographic regions
- 400,000 individuals with developmental disabilities
- Supporting people to:
  - Make developmental progress
  - Maintain children at home
  - Enhance independence



Regional Center Roles

- Assessment, diagnosis, and referrals
- Lifelong individualized planning and service coordination
- Assistance in finding and accessing community and other resources
- Payment for services for which other funds are not available
- Development of new services to better meet individual needs

Regional Center Determination of Level of Care Criteria

- Member expresses interest in ICF/DD Home to their Service Coordinator, who will lead subsequent activities
- Level of Care Assessment is scheduled within two weeks to determine the appropriate level of care per CCR Title 22 Sections 51343, 51343.1, and 51343.2
- Planning team meets to discuss the process, discuss a tour of the ICF/DD Home and/or a meet and greet
- Assessment is completed by a nurse, and documentation (Individual Program Plan, Social Summary, Psychological Evaluation, Individual Support Plan, etc.) is sent to the ICF/DD Home for review
- ICF/DD Home agrees to placement and planning team work together on a move in date

Regional Center Determination of Level of Care Criteria

- Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD, ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures “as needed” are not appropriate for ICF/DD-H and ICF/DD-N placement.
- Federal requirements for monitoring utilization and quality of care include:
- A review of the recipient’s plan of care every 90 days by the ICF/DD Home’s interdisciplinary team.
- A comprehensive medical and social evaluation of the member within 12 months prior to admission.
- Recertification by physician of the level of care at least every 60 days.
- A requirement that the member be seen by the attending physician at least every 60 days, or 90 days if approved by a Medi-Cal consultant.
- Reassessment by the Regional Center occurs at least every two years.

Meet Ramona

- Ramona is a 53-year-old female diagnosed with Down syndrome. She has moderate intellectual disability as well as a heart defect. She also has arthritis in her knees, for which she is receiving physical therapy.
- Ramona is on medication for depression and has some short-term memory loss.
- She enjoys ice cream and singing along to movie musicals.

Meet Ramona

- Ramona currently lives in an ICF/DD-H Home and has done so for the past 20 years since her mother passed away. She has no siblings and has had no contact with her father since infancy. Her best friend is her roommate in the ICF/DD-Home.
- Ramona is currently on Medicare as well as Medi-Cal Fee for Service (FFS). Her ICF/DD-H Home services are about to transition to a Managed Care Plan as part of the Long-Term Care Carve In.

Ramona's Transition of Services

Choice of Living Arrangement (Lanterman Act)

Ramona lives in an ICF/DD-H Home which is currently paid for by Medi-Cal FFS. She wants to continue to live in her current Home when the Home transitions into managed care.

Regional Center Role

The Regional Center will work with the individual/Home to assist them in the transition process. Ramona has already been assessed for diagnosis and ICF/DD level of care requirements per CCR Title 22 Sections 51343, 51343.1, and 51343.2.

ICF/DD Home Role

The ICF/DD-H Home will contract with the MCP. DHCS will share the pre-existing FFS authorization through a data transfer to the MCP.
The Home will work with the LTSS liaison at the MCP as needed.

MCP's Role

MCP will continue Ramona's authorization and begin payment to the ICF/DD-H Home. The MCP will now pay for Ramona's other Medi-Cal services.

Meet Joe

- Joe is a 55-year-old male who has been diagnosed with Intellectual Disability (Moderate) and Autism Spectrum Disorder (ASD). He was diagnosed when he was three due to not sitting. talking, or walking at the same time as other people the same age. He has difficulty developing and maintaining friendships, communicating with peers and staff, and understanding what behaviors are expected when interacting with peers and staff.
- Joe has been diagnosed with anxiety. He often has trouble expressing himself verbally, especially in crowded and/or loud areas. He communicates best with visual signs, including pictures and sign language. He currently takes Prozac and Gabapentin to help him control his anxiety and mood instability.
- Joe likes coffee, being around animals and using his tablet to play interactive video games.

Meet Joe

- Joe has very limited family support at this time. His father died when he was fifteen and he moved into a **group home** when he was 22. Joe's mother, who visited him every day and was very supportive, is now in an adult care home and has been diagnosed with dementia.

- **Joe is in now in need of an ICF/DD–H Home**. He has been having increased difficulty with emotional regulation, such as non-verbal rocking back and forth, and increased difficulty with his dental and general hygiene, and with bathing and dressing Activities of Daily Living (ADLs).

Resident Entry Into an ICF/DD-H Home

Choice of Living Arrangement (Lanterman Act)

Joe has chosen to move to an ICF/DD Home–H after consultation with his conservator. Joe and his conservator contacted the Regional Center to make this request.

RC Assessment

The Regional Center assessed Joe for ICF/DD level of care requirements per CCR Title 22 Sections 51343, 51343.1, and 51343.2.

RC Referral and ICF/DD Home Confirmation

The Regional Center submitted a referral packet to the ICF/DD-H Home for review. The ICF/DD-H home confirmed bed availability and capacity to serve Joe in the home and notified the Regional Center by phone within 14 days.

MCP's Role

MCP receives request from ICF/DD-H Home and reviews authorization for Joe, and begins payment to the ICF/DD-H Home upon Joe moving into the Home.

Individual Program Plan vs. Individual Service Plan

Individual Program Plan

Regional Centers develop an Individual Program Plan (IPP) for each individual with intellectual and developmental disabilities based on the member's person-centered goals and needs. An IPP serves as a **contract between the Regional Center and its members** and identifies (1) all services and supports the member 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 MediCal. The IPP process is centered on the individual, and if appropriate, the individual's parents, legal guardian or conservator, or authorized representative.

Individual Service Plan

The Individual Service Plan (ISP) is developed by the ICF/DD Facility/Home's interdisciplinary professional staff/team and includes participation of the member and anyone of their choosing, including direct care staff, and should include all relevant staff of other agencies involved in serving the member. 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. The ISP is completed 30 days following a transition to an ICF/DD Facility/Home. It includes active treatment goals.

Individual Program Plan

Regional Center Role

Joe worked with his service coordinator at the Regional Center to update a service plan with his conservator, regional center staff, and ICF/DD Home Staff. Joe did not want anyone else to participate in his plan.

The team ensured that services supported Joe's choices including where he lives, how he spends the day, and his hopes and dreams for the future.

His IPP includes his need to be mindful of his diet and exercise to help with his oral health and anxiety, as well as the need for ongoing integrated care with his primary care physician, his dentist, and his psychiatrist. Joe indicated that he wants to begin a day program. Other goals in his IPP are to find a girlfriend, work with animals, and continue to be able to use his tablet and play visually interactive games.

ICF/DD Home Role

ICF/DD Home staff participate in the IPP development process and use this information in developing the Individualized Service Plan (ISP). It will include services covered by the RC.

MCP Role

The MCP will not receive the IPP. **Only ICF/DD-N Homes are required to send a copy of the ISP to the MCP.** See next slide for information the MCP will receive.

Individualized Service Plan

Regional Center Role

Regional center staff may participate in the development of the ISP at the request of Joe and his conservator.
The Regional Center will receive a copy of the ISP and will audit whether the ISP services are being delivered.

ICF/DD Home Role

Joe and his conservator also worked with the ICF/DD Home staff on an Individual Service Plan that outlines the ways to attain his personal goals based on his comprehensive functional assessment and as defined in his IPP. The document includes the active treatment (AT) goals, objectives, and methodology, and was developed within 30 days of admission.

Joe's goals included exercising for at least half an hour three days a week, reducing his aggressive behavior by one episode a week, and physical therapy to improve his range of motion.

MCP Role

The MCP will utilize the TAR process to authorize services within their purview and will pay for services covered under managed care.

Hospitalization of Resident

Emergency Medical Hospitalization

While in the ICF/DD-H Home Joe developed pneumonia and had to be sent to the hospital for treatment.

Bed Hold

Joe's doctor issued a physician order for a bed hold for seven days due to his pneumonia so that Joe would be able to go back to his ICF/DD home upon discharge.

ICF/DD Home Role

The ICF/DD Home will hold Joe's bed for seven days and bill/invoice for seven bed hold days to the MCP. The ICF/DD Home notifies Joe's conservator of the right to the Bed Hold provision.

MCP Role

The MCP receives notification of the bed hold from the ICF/DD-H Home and will authorize and pay for the hospitalization and the bed hold.

Post Hospitalization Scenario One

Return to the ICF/DD Home

Joe was medically cleared by the hospital and returned to his bed in the ICF/DD Home. He indicated his choice to return to the same Home.

ICF/DD Home Role

Joe returns to the Home and the Home reviews his ISP for any necessary updates.

Regional Center Role

The Regional Center is aware of Joe's hospitalization and monitors for any possible additionally needed services.

MCP Role

The MCP continues with the authorization and payment for Joe's ICF/DD Home as per 22 CCR sections 51535 and 51535.1

Post Hospitalization Scenario Two

New Level of Care Required

Joe's pneumonia progressed instead of clearing quickly with antibiotics. He required ICU Care and became significantly debilitated. He now requires a higher degree of care.

Person Centered Decision Made

After a discussion with his conservator, they decided he would like to be in an ICF/DD-N Home. His IPP and ISP were updated to reflect his medical changes and the need for increased medical care.

ICF/DD Home Role

The ICF/DD Home-H will assist in a warm transfer of Joe, his belongings, his ISP, and important things to know about Joe such as food preferences and behavioral triggers.

Regional Center Role

The Regional Center reassessed Joe and updated his IPP, and sent a referral to an ICF/DD-N Home

MCP Role

The MCP receives a request from the new ICF/DD-N Home and uses it as the basis to authorize services for Joe.

Meet Rico

- Rico is a 30-year-old male diagnosed with cerebral palsy. He has a motorized wheelchair and has dysphagia, leading to some coughing after eating or drinking. He requires assistance with bathing, toileting, and eating.
- Rico did go to college and majored in English before his musculoskeletal condition worsened, and he enjoys listening to books on tape and is recording a novel of his own.
- Rico enjoys reading and writing poetry with an assistive device, and relishes heavy metal music.

Meet Rico

- Rico currently lives in an ICF/DD Home and has done so for the past 5 years. He has a brother who was in the military but has now returned to California. He works from his own home as an IT technician. Rico would like to live with his brother and has requested to be referred for a Home and Community Based Services Waiver slot.
- Rico will need personal care assistance as well as care management when he moves to his brother's home, including home modifications to make the home wheelchair accessible.

Member Transition to HCBS Waiver

Rico decides to seek Community Based Services

Rico determines that he wants to move into his brother's home and applies for an HCBS waiver for services to support him in the community.

Regional Center Role

Rico has been engaged with and assessed by the Regional Center for his eligibility for an institutional level of care. The Regional Center coordinates, provides, arranges or purchases all waiver services and is responsible for service provider contracts and payments.

ICF/DD Home Role

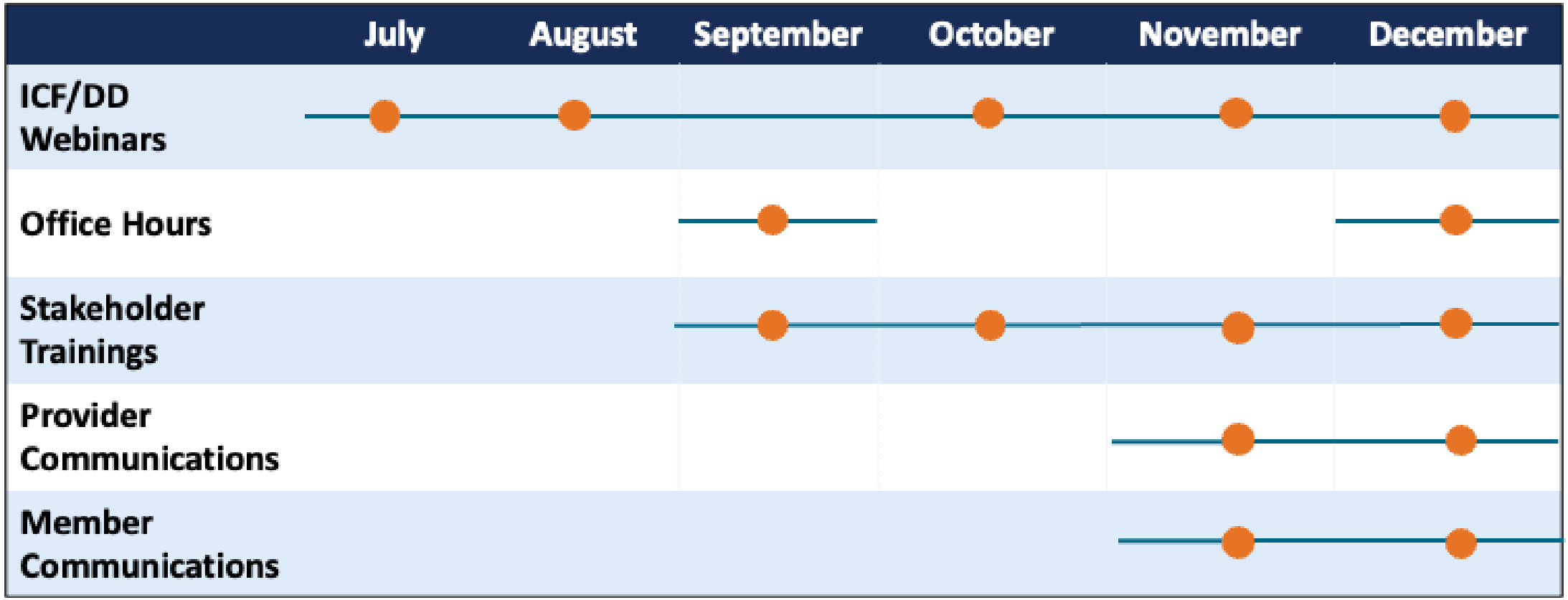
The ICF/DD Home will assist in a warm transfer of Rico.

MCP Role

The MCP care management team works closely with the Regional Center to coordinate Rico's services and supports. Rico's waiver services and supports will be funded through the waiver. Other needs will be met by the MCP.

Questions

ICF/DD Transition: Communications and Outreach



** All content and timing is subject to change*

ICF/DD Upcoming Webinars

Topic*	Audience	Date and Time
CalAIM ICF/DD Home 101 for MCPs	MCPs only	July 12, 2023 10-11am
Managed Care 101 for ICF/DD Homes	ICF/DD Homes & Regional Centers	August 21, 2023 2:30-3:30pm
Promising Practices or Care Management	ICF/DD Homes, Regional Centers, and MCPs	October 6, 2023 10-11am
Billing and Payment	ICF/DD Homes, Regional Centers, and MCPs	November 17, 2023 1-2pm
How Medi-Cal Supports ICF/DD & Subacute Residents	ICF/DD Homes, Regional Centers, Subacute Facilities and MCPs	December 15, 2023 2-3pm

**These topics are tentative and may be subject to change.*

Appendix

TAR Process for ICF/DD Homes

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TAR Process Flowchart — *Current*

Choice of Living Arrangement (Lanterman Act)

Individual chooses to move to ICF/DD Home

RC Assessment

Regional Centers assess if individual meets ICF/DD level of care requirements per CCR Title 22 Sections 51343, 51343.1, and 51343.2

RC Referral Packet

Regional Centers submit a referral packet, which includes all relevant diagnostic information, to the ICF/DD home for review.

ICF/DD Home Confirms

The ICF/DD home confirms bed availability and capacity to serve the individual in the home and notifies the Regional Center by phone or email.

TAR Process Flowchart — *Current*

ICF/DD Home Completes Packet

The ICF/DD home completes and submits to DHCS or COHS plan, the following information for authorization:

- A Certification for Special Treatment Program Services form (HS 231) signed by the Regional Center with the same time period requested as the TAR (shows LoC met).
- A Treatment Authorization Request (TAR) form [Long Term Care Treatment Authorization Request (LTC TAR, 20-1)]
- A Medical Review/Prolonged Care Assessment (PCA) form (DHCS 6013A) OR the information found on the PCA form in any format (e.g., a copy of the Individual Program Plan (IPP) or Individual Service Plan (ISP)).
- ICF/DD-N homes are required to include an ISP whenever a TAR reauthorization is submitted as mandated in the Medi-Cal Provider Manual (TAR for Long Term Care: 20-1 Form (tar ltc) page 3).
- ISP submissions are required as part of the periodic review of ICF/DD-N homes as mandated by CCR Title 22, Section 51343.2(k).

DHCS or COHS Plan Completes Review

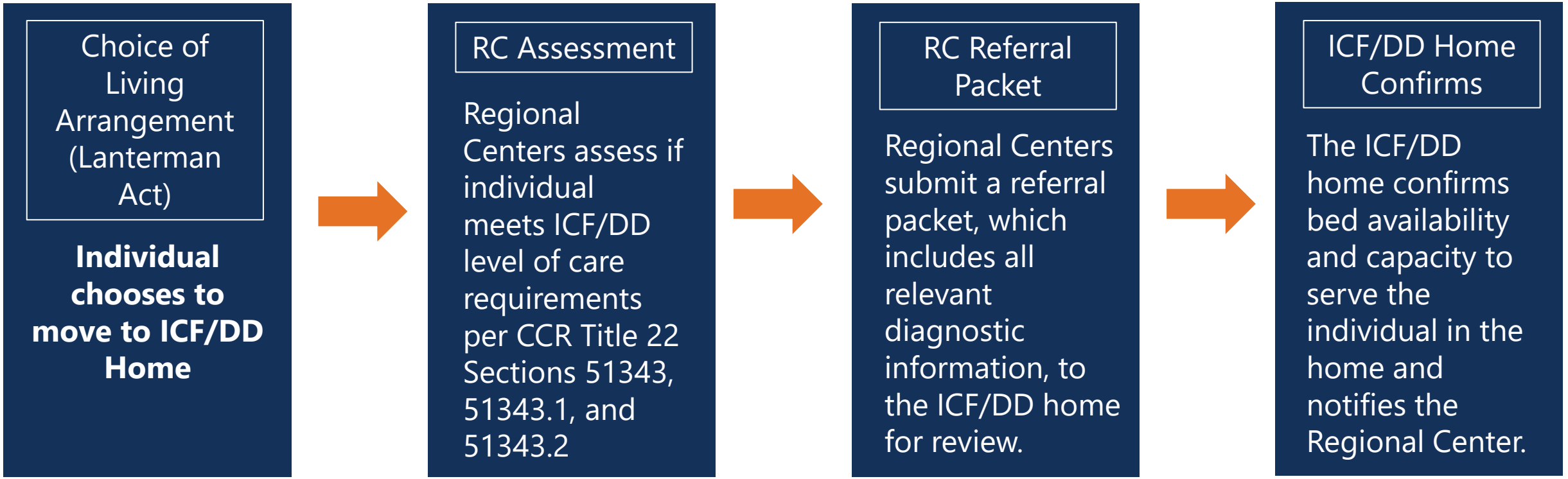
DHCS or COHS Plan reviews the submitted TAR form, HS231 form, 6013A form (or alternative information) and any attached documentation showing medical necessity, current care needs, and recipient prognosis, and makes a medical necessity determination and authorization decision (approval or denial).

Authorization Communicated to ICF/DD Home

DHCS or COHS Plan communicates the authorization decision to the ICF/DD home.

TAR Process Flowchart — *Post-Carve-In*

» **What is changing?** Following the ICF/DD Carve-In MCPs (not DHCS) will receive, process, and render medical necessity decisions for ICF/DD services.



MCPs and ICF/DD homes will be required to follow the Medi-Cal Provider Manual requirements related to long-term care services for ICF/DD services: TAR Completion for Long Term Care (tar comp ltc) (pp. 4–6); TAR for Long Term Care: 20-1 Form (tar ltc); (pp. 3, 8) and Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) (ca.gov) (list of services).

TAR Process Flowchart — *Post-Carve-In*

ICF/DD Home Completes Packet

The ICF/DD home completes and submits to the **MCP** the following information for authorization:

- A Certification for Special Treatment Program Services form (HS 231) signed by the Regional Center with the same time period requested as the TAR (shows LoC met).
- A Treatment Authorization Request (TAR) form [Long Term Care Treatment Authorization Request (LTC TAR, 20-1)].
- A Medical Review/Prolonged Care Assessment (PCA) form (DHCS 6013A) OR the information found on the PCA form in any format (e.g., a copy of the IPP or ISP).
- ICF/DD-N homes are required to include an ISP whenever a TAR reauthorization is submitted for an individual as mandated in the Medi-Cal Provider Manual (TAR for Long Term Care: 20-1 Form (tar ltc) page 3)
- ISP submissions are required as part of the periodic review of ICF/DD-N homes as mandated by CCR Title 22, Section 51343.2(k).

The same forms will be used post carve-in.

MCP Completes Review

The MCP reviews the submitted TAR form, HS231 form, 6013A form (or alternative information) and any attached documentation showing medical necessity, current care needs, and recipient prognosis, and makes a medical necessity determination and authorization decision (approval or denial).

MCP Communicates Authorization to ICF/DD Home

The MCP communicates the authorization decision to the ICF/DD home.

TAR Process Flowchart — *Post-Carve-In*

MCPs and ICF/DD homes will be required to follow the Medi-Cal Provider Manual requirements related to long-term care services for ICF/DD services:

- TAR Completion for Long Term Care (tar comp ltc) (pp. 4-6)
- TAR for Long Term Care: 20-1 Form (tar ltc) (pp 3, 8); and
- Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) (ca.gov) (list of services).

Project Timeline

Milestones	Quarter 1 2023	Quarter 2 2023	Quarter 3 2023	Quarter 4 2023	Q1 2024
Conduct Interviews with key ICF/DD facilities and stakeholders.					
Review, research, and create an Inventory of Requirements for ICF/DD.					
ICF/DD Workgroup Meetings **Others may be added as needed**					
Identify key themes to address in APL and in other policy guidance as needed.					
Research and work with internal and external stakeholders to draft, vet, and revise the APL.					
Conduct and complete Network Readiness by October 2023.					

Project Timeline

Milestones	Quarter 1 2023	Quarter 2 2023	Quarter 3 2023	Quarter 4 2023	Q1 2024
Research and work with internal and external stakeholders to draft, vet, and revise billing/invoicing guidance, sample provider contract language, and Promising Practices by mid-February.					
Member noticing					
Data sharing					
Target date to issue Draft APL for public comment.		★			
Educational Webinars (Provider-facing trainings; MCP-facing trainings)			★		
Issue final APL.					

Previous Meeting Materials

- As a reminder, previous ICF/DD Carve-in Workgroup meeting materials are linked from the LTC ICF/DD web page.
- Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In

Glossary

Term	Definition
APL	All Plan Letter
CAD	Clinical Assurance Division
CAHF	California Association of Health Facilities, a professional organization of providers of long-term care services
CAHP	California Association of Health Plans
CalAIM	California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.
CCR	California Code of Regulations
CDPH	California Department of Public Health
Choice Packets	Packets of information mailed to members notifying them of their rights and responsibilities pertaining to ICF/DD carve-in.
COHS	County Organized Health System
CRDD	Capitated Rates Development Division
DDS	Department of Developmental Services
DHCS	Department of Health Care Services

Glossary

Term	Definition
DSN	Developmental Services Network - An ICF services trade association
ECM	Enhanced Care Management
FFS	Fee-for-Service
FFSRDD	Fee-for-Service Rate Development Division
HCDS	Health Care Delivery and Systems
HCF	Health Care Financing
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for Developmentally Disabled
ICF/DD-H	Intermediate Care Facility for Developmentally Disabled-Habilitative
ICF/DD-N	Intermediate Care Facility for Developmentally Disabled-Nursing
IPP	Individual Program Plan
ISP	Individual Service Plan

Glossary

Term	Definition
LHPC	Local Health Plans of California
LOA	Leave of Absence
LTC	Long Term Care
MCP	Managed Care Plan
MCOD	Managed Care Operations Division
MCQMD	Managed Care Quality and Monitoring Division
Medi-Cal	California's Medicaid Program
MOU	Memoranda of Understanding
NOAI	Notice of Additional Information (in the context of member noticing)
P&P	Planning & Policy
QI	Quality Improvement
RC(s)	Regional Center(s)
TAR	Treatment Authorization Request