Managed Care Resources for LTC Providers

Long-Term Care Learning Series

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

December 17, 2024

Meeting Management

- This session is being recorded.
- Participants are in listen-only mode.
- Please use the “chat feature” to submit any questions you have for the presenters.
  - During Q&A, to expand further on a question submitted to the chat, please use the "Raise Hand" feature, and our team will unmute you.

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- Select “Rename.”
- Enter your name and add your organization as you would like it to appear.
  - For example: Kristin Mendoza-Nguyen – Aurrera Health Group

Agenda

Topics	Time
Overview of Long-Term Care (LTC) Carve-In & LTC Learning Series Background	9:00 – 9:10 a.m.
Medi-Cal Eligibility & Managed Care Plan (MCP) Enrollment	9:10 – 9:25 a.m.
Q&A	9:25 – 9:33 a.m.
LTC Authorizations	9:33 – 9:43 a.m.
Q&A with CalOptima & Community Health Group	9:43 – 10:00 a.m.
Managed Care Billing & Payment	10:00 – 10:08 a.m.
Q&A with CalOptima & Community Health Group	10:08 – 10:26 a.m.
Closing and Next Steps	10:26 – 10:30 a.m.

LTC Carve-In Overview & LTC Learning Series Background

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CalAIM LTC Carve-In Goals

All Medi-Cal managed care plans are responsible for the full LTC benefit across Skilled Nursing Facilities (SNFs), Subacute Care Facilities, and Intermediate Care Facilities for Developmentally Disabled (ICF/DD) Homes

- Standardize LTC services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in LTC facilities.
- Facilitate a seamless transition for LTC members with no disruptions in access to care or services.
- For ICF/DD Homes, maintain the existing infrastructure of ICF/DD Homes and Regional Centers, which includes Lanterman Act protections and the roles and responsibilities of Regional Centers.

LTC Continuity of Care Policy Reminder

For Members that transitioned from Medi-Cal Fee-for-Service to Medi-Cal managed care, MCPs are required to automatically provide 12 months of Continuity of Care for the ICF/DD Home and Subacute Care Facility placement.

- This CoC policy ensures that a member's Home or Facility will not change during the CoC period even if the Home or Facility does not have a contract with the member's Managed Care Plan (MCP).
- While CoC is automatic for the first 12 months after a member transitions into an MCP, Members or their authorized representatives may **request an additional 12 months of CoC.**
- MCPs are required to notify members at least 30 days in advance of an expiring CoC period and furnish a copy of the notification to the Home or Facility.
- Refer to the CoC policy detailed in APL 23-022, ICF/DD APL 24-011, Subacute Care Facility APL 24-010, and in the ICF/DD CoC Letter to Plans.

LTC Stakeholder Landscape Assessment

- DHCS sought feedback from various stakeholders on their experience implementing the 2023 and 2024 CalAIM LTC Carve-In.
- This feedback informed the LTC Learning Series.
- Stakeholder Landscape Assessment, Summer 2024
  - 11 interviews with Managed Care Plan, LTC Provider, Regional Center, and LTC Ombudsman stakeholders across 28 organizations
- LTC Learning Series, Fall/Winter 2024
  - Session 1: Spotlight on Subacute Care Services on 10/7/24 (MCP focused)
  - Session 2: LTC Policy Update on 11/4/24
  - Session 3: Managed Care Resources for LTC Providers on 12/17/24 (LTC Provider focused)

LTC Stakeholder Landscape Assessment

What We Learned:

- The LTC Carve-In transition required changes in approach and operations for all stakeholders.
- Post-implementation challenges are still occurring, particularly when it comes to billing/claims.
- MCP communication with LTC providers varies widely.
- MCPs found it challenging to onboard LTC providers who were new to managed care, given the complexities of managed care processes and LTC providers' health information technology capacities.
- LTC providers continue to encounter challenges in navigating managed care processes and effectively communicating and resolving concerns with MCPs.

LTC Stakeholder Landscape Assessment

Highlighted Promising Practices:

- Regular meetings among stakeholders are important for problem-solving and strengthening relationships.
- Pursuing and/or strengthening relationships with other entities, like counties or hospitals, or Community Health Workers, are key in ensuring LTC members are fully supported.
- MCPs using a multi-prong approach (LTSS liaison, PHM outreach specialists, social workers, etc.) when engaging with LTC providers helps address gaps in understanding and communication.
- MCPs providing regular trainings and education opportunities for providers new to managed care helps to build foundational knowledge of how plans operate and informs what questions providers need to ask plan partners. It also provides another opportunity to have dialogue.
- Ensuring messaging on policy and processes is clear and streamlined is key for stakeholder understanding and consistent implementation.

Managed Care Resources for LTC Providers

LTC Provider Resources

- Medi-Cal Eligibility & MCP Enrollment
- LTC Authorizations
- Managed Care Billing & Payment

Learning Objectives

» Review key information from the newly developed **Resources for LTC Providers**, including step-by-step processes, helpful tips, and valuable links

» Engage with MCP co-presenters to discuss insights and best practices related to the Resources for LTC Providers topics

Medi-Cal Eligibility & MCP Enrollment

Resource for LTC Providers

Overview

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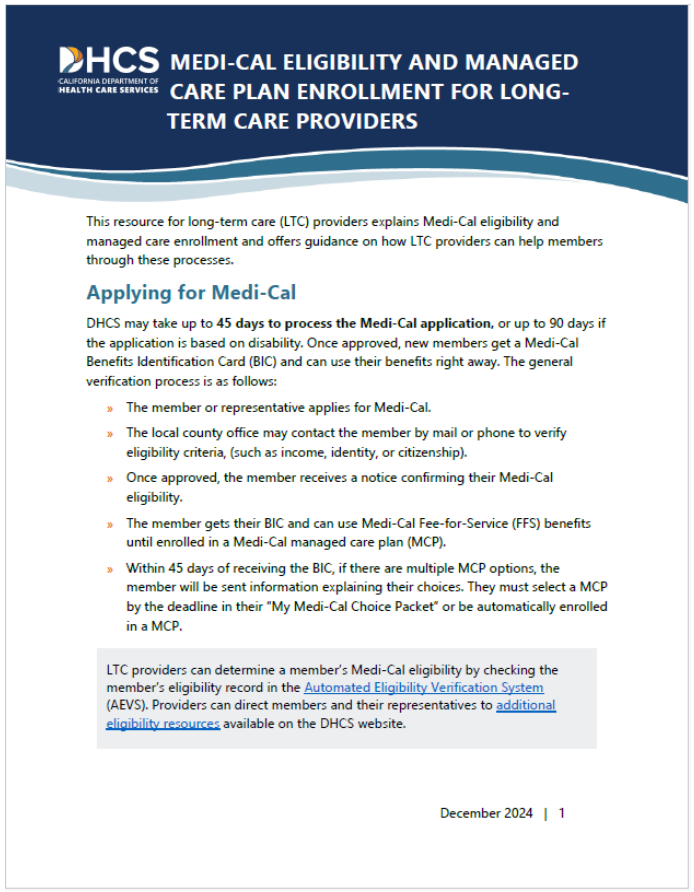
Medi-Cal Eligibility & MCP Enrollment Resource



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MEDI-CAL ELIGIBILITY AND MANAGED CARE PLAN ENROLLMENT FOR LONG-TERM CARE PROVIDERS

This resource for long-term care (LTC) providers explains Medi-Cal eligibility and managed care enrollment and offers guidance on how LTC providers can help members through these processes.

Applying for Medi-Cal

DHCS may take up to **45 days to process the Medi-Cal application,** or up to 90 days if the application is based on disability. Once approved, new members get a Medi-Cal Benefits Identification Card (BIC) and can use their benefits right away. The general verification process is as follows:

- The member or representative applies for Medi-Cal.
- The local county office may contact the member by mail or phone to verify eligibility criteria, (such as income, identity, or citizenship).
- Once approved, the member receives a notice confirming their Medi-Cal eligibility.
- The member gets their BIC and can use Medi-Cal Fee-for-Service (FFS) benefits until enrolled in a Medi-Cal managed care plan (MCP).
- Within 45 days of receiving the BIC, if there are multiple MCP options, the member will be sent information explaining their choices. They must select a MCP by the deadline in their "My Medi-Cal Choice Packet" or be automatically enrolled in a MCP.

LTC providers can determine a member's Medi-Cal eligibility by checking the member's eligibility record in the Automated Eligibility Verification System (AEVS). Providers can direct members and their representatives to additional eligibility resources available on the DHCS website.

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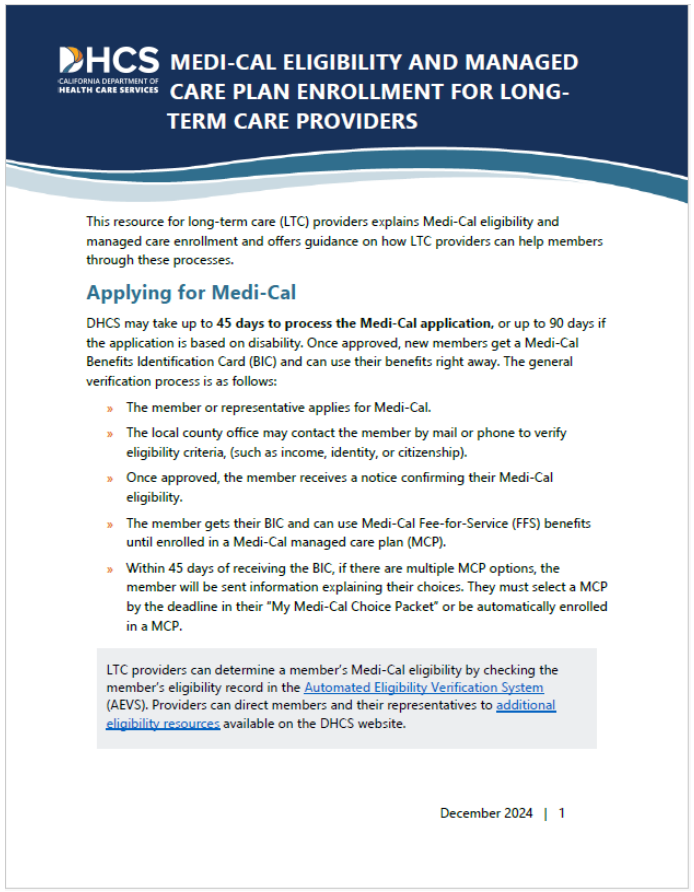
Objectives

- Summarizes key Medi-Cal eligibility and MCP enrollment information
- Provides LTC provider-specific guidance on supporting members navigating these processes
- Provides links to existing DHCS Medi-Cal eligibility and MCP enrollment information

Medi-Cal Eligibility & MCP Enrollment Resource



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Sections

- Applying for Medi-Cal
- Enrolling in a Medi-Cal MCP
  - Member Choice
  - Medi-Cal MCP Subcontracting
    - Delegation
    - Participating Provider Groups (PPGs)
  - Resources Provided to Members Newly Enrolled in an MCP
- How LTC Providers Can Support Medi-Cal Members

Applying for Medi-Cal

- Medi-Cal application may take 45 days to process, 90 days if based on a disability
- Once approved, Medi-Cal coverage is available right away
  - The member has Fee-for-Service Medi-Cal until they are enrolled in a Managed Care Plan (MCP)
  - **LTC providers should bill FFS during this time**
- If the member has more than one plan option, the member has until the date listed in the "My Medi-Cal Choice Packet" to choose an MCP
- If a member does not choose an MCP, they will be automatically enrolled in an MCP chosen by Medi-Cal

Applying for Medi-Cal

- To determine a member's eligibility status and which MCP they are enrolled in, check the member's eligibility record in the Automated Eligibility Verification System (AEVS)
- LTC providers can refer members to the Steps to Medi-Cal DHCS webpage for additional information

Enrolling in a Medi-Cal MCP

- MCP enrollment is based on the county in which a member resides
- There are **five managed care county models** that determine if or how a member can choose an MCP

Enrolling in a Medi-Cal MCP

Member Choice

A Medi-Cal member's MCP choice depends on their county of residence and whether they are "dually eligible" for both Medi-Cal and Medicare and already enrolled in a Medicare Advantage Plan. LTC providers should use AEVS to identify a member's assigned MCP. As illustrated in the table below, there are five managed care county models. Refer to the DHCS Medi-Cal MCPs by County and Medi-Cal MCP Model Fact Sheet for more information.

County Model	Model Description	Member Choice, if applicable
Geographic Managed Care (GMC)	DHCS contracts with multiple Knox-Keene licensed commercial MCPs serving defined geographical areas.	If a member resides in a GMC, Two-Plan, or Regional County and is **not** enrolled in a Medicare Advantage Plan with a matching MCP, the member can enroll in a MCP in the following ways: » **Mail** in the *My Medi-Cal Choice* form that comes with their *My Medi-Cal Choice* packet. » **Online** at Medi-Cal Health Care Options (HCO) through their login and member page. » **Over the Phone** with Medi-Cal HCO Customer Service at 1-800-430-4263 (TTY:1-800-430-7077) (Available 8 am – 6 pm, Monday to Friday). » **In-Person** at the member's local County Social Service Office.
Two-Plan	DHCS contracts with two Knox-Keene licensed MCPs, a county-authorized plan called a Local Initiative and a commercial MCP.	
Regional	DHCS contracts with two Knox-Keene licensed commercial MCPs serving two or more contiguous counties in the designated Rural Expansion Regional. This is a model for rural counties that have not elected to participate in the County-Organized Health Systems (COHS) or Two-Plan model.	

Enrolling in a Medi-Cal MCP

- If a member is enrolled in a Medicare Advantage plan and resides in one of the 17 Medi-Cal matching plan policy counties, they will be enrolled automatically in that matching Medi-Cal MCP
- For a list of MCPs by county, refer to the DHCS Medi-Cal MCPs by County document (as of 2023 and 2024)
- To determine which MCP a member is enrolled in, check AEVS

Enrolling in a Medi-Cal MCP

Member Choice

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MCP Subcontracting

Delegation

- MCPs, referred to as Prime Plans, may assign members to other MCPs, referred to as Delegated Subcontractors
- Providers should check if a member is assigned to a Delegated Subcontractor by checking the Prime Plan's provider portal or by viewing the member's health plan ID card

Prime Plan	Delegated Plan
LA Care	Anthem
	Blue Shield Promise
Health Net	Molina

Participating Provider Group (PPG) or Independent Practice Association (IPA)

- MCPs may subcontract services to a group of providers (PPG or IPA)
- Depending on the MCP, providers may need to directly contract with and bill the PPG or IPA
  - Provider MCP contracts include a Division of Financial Responsibility identifying who to bill
- Providers should check the MCP provider portal or member health plan ID card to determine if a member has been delegated to a PPG or IPA

MCP Resources Provided to Newly Enrolled Medi-Cal Members

- Once enrolled in an MCP, the member will receive a letter from Health Care Options (HCO) confirming the MCP and effective date
- The member will receive:
  - Member Handbook (Evidence of Coverage)
  - Provider Directory
  - All mailings and notices critical to obtaining services such as Notices of Action, Notice of Adverse Benefit Determination, Grievances or Appeals, preventive health reminders, and notices advising of the availability of free language assistance
- MCPs are required to post their Member Handbook and Provider Directory on their website
- The MCP and HCO will send this information in the manner preferred, including in alternate formats such as Braille, large-print font, or audio
- LTC providers should reach out to the MCP LTSS Liaison if the member did not receive the Member Handbook or Provider Directory, or if it is not available online

How LTC Providers Can Support Medi-Cal Members

How can LTC providers support residents applying for or maintaining Medi-Cal eligibility?

- Anyone who knows of a potential applicant's need to apply to Medi-Cal can submit an application for the purpose of preserving the date of application.
- Potential applicants who cannot act for themselves shall not be denied (or discontinued) Medi-Cal coverage solely for the reason that there is no entity assigned to act for them
- If there is no spouse, conservator, guardian, or executor and the applicant is not considered competent, LTC providers may be able to act on a resident's behalf by contacting their local county social services office and informing the office of the applicant's known circumstances
- Refer to All County Welfare Directors' Letter 94-62 for more information

How LTC Providers Can Support Medi-Cal Members

How can LTC providers support members with enrollment when there is a change in their county of residence?

- LTC providers should be familiar with the Intercounty Transfer (ICT) process:
  - Members are responsible for notifying either the county they are moving from or to of their change in residence in-person, in writing, telephonically, or online
  - Within seven days of being notified, the notified county will initiate the ICT with the non-notified county
  - The ICT must be completed 30 days after the member's initial notification
  - For more information refer to All County Welfare Directors' Letter 18-02E
- During the transfer, members are entitled to the full scope of benefits through FFS Medi-Cal
- LTC providers can act as a liaison during the transfer, ensuring the member continues to receive care throughout the process

How LTC Providers Can Support Medi-Cal Members

How can LTC providers support members with enrollment when there is a change in their county of residence?

- A transferring member may be unable to enroll in a MCP in their new county if there is a mismatch between the address and county code in the DHCS Medi-Cal Eligibility Database System (MEDS)
- LTC providers can direct members or their authorized representatives to contact their local county office to update their address
- Members with a mismatched address in MEDS will remain in FFS Medi-Cal until their address is updated

Question Logistics

- **To ensure DHCS covers as many questions as possible, please follow the guidelines below:**
  - Please submit your questions via the Zoom Chat function.
  - If your question is chosen and you would like to provide more context or clarification, please use the “raise hand” function and a team member will unmute you.

LTC Authorizations

Resource for LTC Providers

Overview

DHCS

LTC Authorizations Resource

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL AUTHORIZATIONS FOR LONG-TERM CARE PROVIDERS

This quick reference guide can help long-term care (LTC) providers navigate the Medi-Cal authorization process for Skilled Nursing Facility (SNF), Subacute Care, and Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home services.

Authorization for Institutional LTC

Authorization is a process in which providers obtain approval from a Medi-Cal member's managed care plan (MCP) before providing a specific item, service, or medication. Every MCP has its own procedures and forms for handling authorization requests, so providers must understand and follow the specific processes for each of contracted MCP.

This document helps LTC providers by outlining common steps for authorization, providing useful tips such as questions to ask MCPs, a checklist to support successful submissions, and a quick reference guide for LTC authorizations.

Step One: Submitting the Authorization Request

LTC authorization requests can typically be made through the MCP's online portal, by fax, or by phone. An authorization request form is required. This form details member and provider information, diagnosis, service information, requested coverage, the physician's order or signature, and proof of medical necessity, which may require additional documents. This information is important as it outlines how a member meets

Authorization Quick Checklist

The checklist below helps ensure a successful initial authorization request submission:

- ✓ Provider information is complete and accurate.
- ✓ Billing address is complete.
- ✓ Member's information is correct.
- ✓ Requested start date and timeframe are included.
- ✓ Updated physician's order is included.
- ✓ All required forms and attachments are included.

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Objectives

- Provide a step-by-step overview of the LTC authorization process
- Support LTC providers with navigating each MCP's authorization process by:
  - Identifying questions to ask each MCP
  - Providing a quick authorization submission checklist
  - Highlighting key authorization information in a quick reference guide

Step One: Submitting the Authorization Request

- Providers can typically submit LTC authorization requests on the MCP's online portal, by fax, or by phone
- A form is required
- The ICF/DD Home service authorization requires the clinical review and recommendation from the coordinating Regional Center

Questions to ask MCP:

- What is the preferred method of submission?
- What additional documentation is required as a part of the authorization request (e.g., what are the common follow up or additional items requested from LTC providers)?
- What is the process for requesting urgent or emergency requests?
- What are the common reasons for LTC authorization denials?

Step One: Submitting the Authorization Request

- After obtaining all information required for an LTC authorization, review for completeness and accuracy
- Refer to the **Authorization Quick Checklist** in the resource

Authorization Quick Checklist

To avoid delays, make sure:

» Provider information is complete and correct
» Billing address is complete
» Member's information is completed and correct
» Requested start date and timeframe is included
» Updated physician's order is included
» All other required forms and attachments are included

Step Two: MCP Reviews the Authorization Request

- MCPs review authorization requests against established medical criteria
- Authorizations for members transitioning from an acute care hospital must be expedited and need to be responded to by MCPs within 72 hours, including on weekends

Questions to ask MCP:

» How can I track my authorization request?

» If I have questions about an MCP follow-up or request for additional documentation or justification, who is the best point of contact at the MCP, and how should I reach out?

» How and when will I be notified of the authorization request decision?

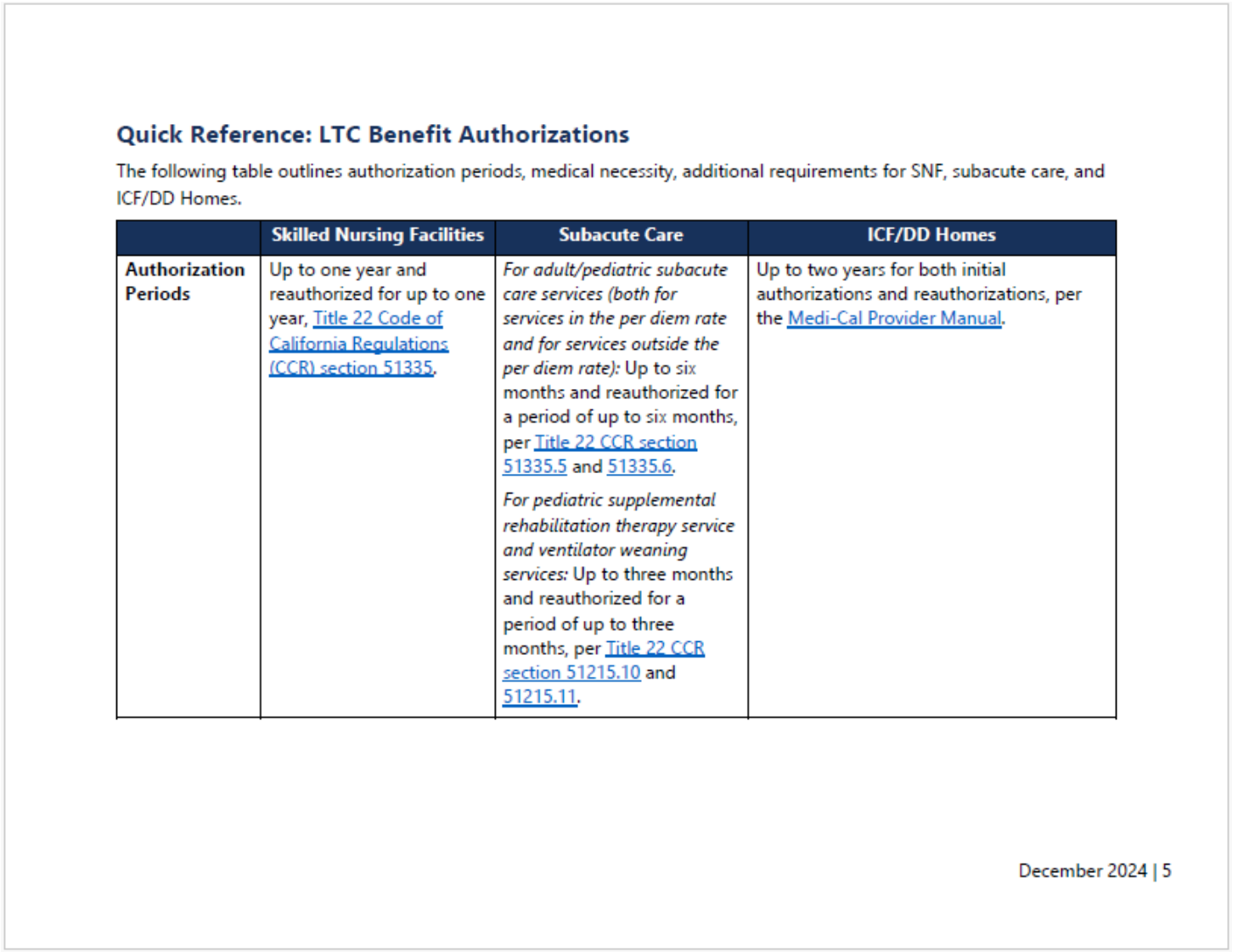
Step Three: MCP Issues an Authorization Decision

- MCPs are to issue a decision as expeditiously as the member's condition requires
- **Routine authorizations**: MCPs must respond within 5 working days and issue a decision within 14 calendar days
- **Expedited authorizations**: MCPs must issue a decision within 72 hours of the request

- If the authorization request is **denied**:
  - The provider may appeal
  - The member or member's authorized representative may apply for an Independent Medical Review if the MCP is Knox-Keene licensed
  - The member or member's authorized representative may request a state hearing

Quick Reference: LTC Benefit Authorizations

- A table at the end of the resource details the following across SNF, Subacute Care, and ICF/DD Home services:
  - Authorization periods
  - Medical necessity
  - Additional requirements



Quick Reference: LTC Benefit Authorizations

The following table outlines authorization periods, medical necessity, additional requirements for SNF, subacute care, and ICF/DD Homes.

	Skilled Nursing Facilities	Subacute Care	ICF/DD Homes
Authorization Periods	Up to one year and reauthorized for up to one year, Title 22 Code of California Regulations (CCR) section 51335.	*For adult/pediatric subacute care services (both for services in the per diem rate and for services outside the per diem rate):* Up to six months and reauthorized for a period of up to six months, per Title 22 CCR section 51335.5 and 51335.6. *For pediatric supplemental rehabilitation therapy service and ventilator weaning services:* Up to three months and reauthorized for a period of up to three months, per Title 22 CCR section 51215.10 and 51215.11.	Up to two years for both initial authorizations and reauthorizations, per the Medi-Cal Provider Manual.

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LTC Authorizations Discussion

Yousaf Farook (Community Health Group), Scott Robinson (CalOptima), & Wendy Magnacca (CalOptima)

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LTC Authorization Discussion with MCPs

- **Avoiding Authorization Denials.** What are the top common reasons for an authorization to be denied or sent back to the LTC provider? Specifically, what guidance or instructions have you provided to LTC providers that has helped to decrease the amount of LTC authorization follow up?
- **Tips and Best Practices.** What are other LTC authorization tips or best practices that you'd like to share with LTC providers?
- **Communicating Authorization Guidance.** How do you communicate guidance to providers on the LTC authorization process? How do providers know if guidance has been updated?

Question Logistics

- Q&A will begin with questions previously submitted via the Zoom Registration form or other forums.
- DHCS will then provide time for open Q&A.

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Managed Care Billing & Payment

Resource for LTC Providers

Overview

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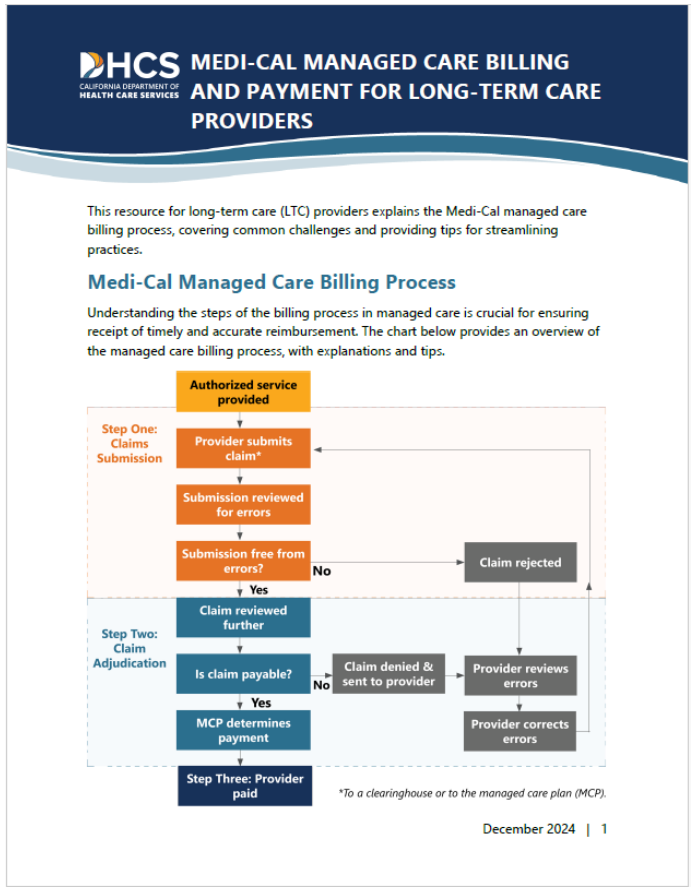
Managed Care Billing & Payment



DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL MANAGED CARE BILLING AND PAYMENT FOR LONG-TERM CARE PROVIDERS

This resource for long-term care (LTC) providers explains the Medi-Cal managed care billing process, covering common challenges and providing tips for streamlining practices.

Medi-Cal Managed Care Billing Process

Understanding the steps of the billing process in managed care is crucial for ensuring receipt of timely and accurate reimbursement. The chart below provides an overview of the managed care billing process, with explanations and tips.

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Objectives

- Summarizes the claims submission process, including receiving payments from MCPs
- Provides LTC provider-specific guidance on how to navigate this process including practical tips and questions to ask each MCP

Step One: Claims Submission

Questions to ask MCPs

- Where can I find resources to assist me with submitting claims?
- Outside of the MCP long-term services and support (LTSS) Liaison, who else can I reach out to for help with submitting claims?

- Providers to submit a **clean claim** according to the **timely filing policy**
  - Review each MCP's billing and payment guidance for timely filing policies and instructions on how to submit a clean claim
- Billing and payment guidance should also outline the acceptable **methods of submission**, including **clearinghouse** information

Step One: Claims Submission

Common Issues & Tips

- **Submitting duplicate claims.** Check the status of a claim before resubmitting. For a denied claim or partial claim payment, submit an appeal instead of resubmitting
- **Incomplete or inaccurate provider information.** Verify that the billing provider information is complete and correct, including National Provider Identifier, Tax Identification Number, name, phone number, and address

Step One: Claims Submission

Tip: To stay up to date on each MCP's billing approach and requirements, regularly review each MCP's published billing guidance, subscribe to MCP newsletters, and attend MCP trainings.

Common Issues

- **Incomplete or incorrect billing codes**. Providers should verify which billing codes are accepted since each MCP may require a different set of billing codes
- **Failing to identify other insurances.** Identifying if a member has other insurance and ensure that it is properly accounted for in the charges reported on the claim. For more information on coordination of Medicare and Medi-Cal benefits, refer to the MCP LTC crossover billing policy in APL 13-003
- **For additional assistance, please review the MCP's billing and payment guidance or reach out to your MCP's LTSS Liaison.**

Step Two: Claims Adjudication

Refer to the MCP billing guidance or contract with the MCP for any questions on the adjudication process. Providers can also refer to the Managed Care Boilerplate Contract for more information on MCP adjudication requirements.

- Claims are subjected to further processing during adjudication, including a review of authorization information
- Tracking submitted claims is essential for ensuring continuity of care and timely payment
- Regardless of contracting status, MCPs are encouraged to allow providers to access electronic billing systems or provider portals to track the status of submitted claims
- **If the claim is determined payable**: The MCP applies the reimbursement rate and any applicable patient cost-sharing to determine the final payment
- **If the claim is determined to not be payable:** The MCP will deny the claim

Step Three: Payment

Questions to ask MCPs

- How will I receive my remittance advice?
- What remittance advice code guidance or crosswalks could be provided to support claims corrections and/or resubmissions?

- The MCP will send payment in the provider's preferred manner
  - *Note*. MCPs cannot provide payments in the form of gift cards
- The **remittance advice** includes payment information and reason codes with descriptions that explain any adjustments or, if denied, the reason for denial

Step Three: Payment

- Providers may receive payments by **Electronic Funds Transfer** (EFT) if the claims are submitted electronically
  - Verify provider information is up to date with the MCP to avoid EFT payment issues or delays
- If a provider feels a claim has been incorrectly paid or denied, they should engage in the **MCP's dispute resolution or claims appeal process**
  - Providers should reach out to their MCP LTSS Liaison to ensure they have the information needed to effectively appeal the decision, including process timelines and documentation requirements

Step Three: Payment

Payment reconciliation can help providers ensure that all payments are received as expected, which in turn, minimizes errors and financial losses.

Payments Reconciliation Tips

- Establish clear and open communication channels with MCPs.
- Keep detailed and accurate billing records.
- Perform regular audits of billing records and payments.
- Provide ongoing training for billing staff to keep them informed about the latest reimbursement policies.
- Utilize software and tools designed to streamline the reconciliation process.
- Develop and implement clear procedures for the reconciliation process.

Managed Care Billing & Payment Discussion

Yousaf Farook (Community Health Group), Scott Robinson (CalOptima), & Wendy Magnacca (CalOptima)

DHCS

Managed Care Billing & Payment Discussion with MCPs

- **Claim Denials**. What are the most common reasons an LTC claim is denied? What steps or considerations would you recommend to LTC providers to prevent these types of denials?
- **Additional Tips and Best Practices.** What additional tips or best practices would you recommend for LTC providers when navigating the billing and payment process, both in general and specific to your plan's procedures?
- **Billing Guidance.** How do you communicate guidance to providers on the billing process and plan-specific standards? How do you inform providers when guidance has been updated?

Question Logistics

- **To ensure DHCS covers as many questions as possible, please follow the guidelines below:**
  - Please submit your questions via the Zoom Chat function.
  - If your question is chosen and you would like to provide more context or clarification, please use the “raise hand” function and a team member will unmute you.

Next Steps & Closing

Looking Ahead

- DHCS continues to conduct monitoring of MCPs.
- MCPs submit data to DHCS on a quarterly basis for review pertaining to provider networks, timely payments, and member grievances.

Resources for LTC Providers

- **DHCS Webpages**
- Skilled Nursing Facility (SNF) CalAIM Carve-In webpage
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD) CalAIM Carve-In webpage
- Subacute Care Facility CalAIM Carve-In webpage

Thank you!

If you have additional questions that were not addressed during this webinar, please email: LTCtransition@dhcs.ca.gov

DHCS