ICF/DD Carve-In Stakeholder Workgroup

Fifth Session
February 10, 2023

DHCS

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: Bambi Cisneros, DHCS

Meeting Management

- The ICF/DD Workgroup meetings are open to the public.
- Non-Workgroup members in attendance are in listen-only mode.
- ICF/DD Workgroup members may submit questions throughout the workgroup, please use the “Chat” feature to submit questions to “All Hosts and Panelists”.
- ICF/DD Workgroup members may also use the “Raise Your Hand” feature on Zoom.

Agenda

- Workgroup charge, goals, and status update
- Discussion Topics for Today
  - Treatment Authorization Request (TAR) process flow
  - Care Coordination and Management
  - Service Provision
  - Bed Holds
- Wrap-up and Next Meeting

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 Department of Health Care Services (DHCS) for the ICF/DD carve-in to Medi-Cal managed care.

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
Karen Widerysnki	California Association of Health Facilities
Scott Robinson	CalOptima
Tami Reid	CenCal
Sylvia Yee	Consumer Voice
Kathy Mossburg	Developmental Services Network
Diane Van Maren	Developmental Services Network
Elizabeth Zirker	Disability Rights California
Edward Mariscal	HealthNet

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

DHCS, DDS, and Contractors – DHCS

DHCS

- **Susan Philip**, Deputy Director, Health Care Delivery and Systems (HCDS)
- **Bambi Cisneros**, Assistant Deputy Director, Managed Care, HCDS
- **Beau Bouchard**, Branch Chief, Capitated Rates Development Division (CRDD)
- **Stephanie Conde**, Branch Chief, Managed Care Operations Division (MCOD)
- **Rafael Davtian**, Division Chief, CRDD
- **Tyra Taylor,** Assistant Chief, Clinical Assurance Division (CAD)
- **Shanell White,** Branch Chief, Clinical Assurance Division (CAD)
- **Dana Durham**, Division Chief, Managed Care Quality and Monitoring Division (MCQMD)
- **Stacy Nguyen**, Branch Chief, MCQMD
- **Alek Klimek**, Chief, Fee-For-Service Rates Development Division (FFSRDD)
- **Lindy Harrington**, Deputy Director, Health Care Financing (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, Managed Care Quality and Monitoring Division (MCQMD)
- **Jalal Haddad**, Project Manager, Health Care Delivery and Systems (HCDS)

DDS and Contractors

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

- **Jason Vogler,** Mercer
- **Kathy Nichols**, Mercer
- **Brittany van der Salm**, Mercer
- **Kayla Whaley,** Mercer
- **Branch McNeal,** Mercer
- **Kristal Vardaman,** Aurrera Health Group
- **Kristin Mendoza-Nguyen**, Aurrera Health Group
- **Winter Koifman**, Aurrera Health Group

Delay of ICF/DD Carve-In

- On February 1, DHCS proposed Trailer Bill Legislation amendments to delay the implementation of the carve-in of Intermediate Care Facility for Developmentally Disabled (ICF/DD) and adult and pediatric subacute care facility services from July 1, 2023, to **January 1, 2024**.
- Effective **January 1, 2024**, members receiving ICF/DD or subacute care facility services will be required to enroll in a Medi-Cal managed care plan (MCP), and DHCS will require MCPs to cover these services.

Policy Questions/Issues Timeline

Category	Policy Questions	Workgroup Review Timeline
Treatment Authorization Request (TAR) process flow	• Review of TAR process flowchart	February 2023
Care Coordination/ Management	• How will MCPs and RCs coordinate their different care management responsibilities for Regional Center clients, including those in ICF/DD homes?	February 2023
	• How will ICF/DD homes, and MCPs when applicable, provide input to the Regional Centers during development of an individual's IPP?	
	• How will the MCP work with the RCs and CDPH to raise ICF/DD home concerns?	
	• How will MCP's submit referrals to Regional Centers when an individual is referred for ICF/DD placement?	
Service Provision	• Will individuals residing in ICF/DD homes be eligible for Enhanced Care Management (ECM)?	February 2023
Bed Holds	• What are the bed hold policies?	February 2023

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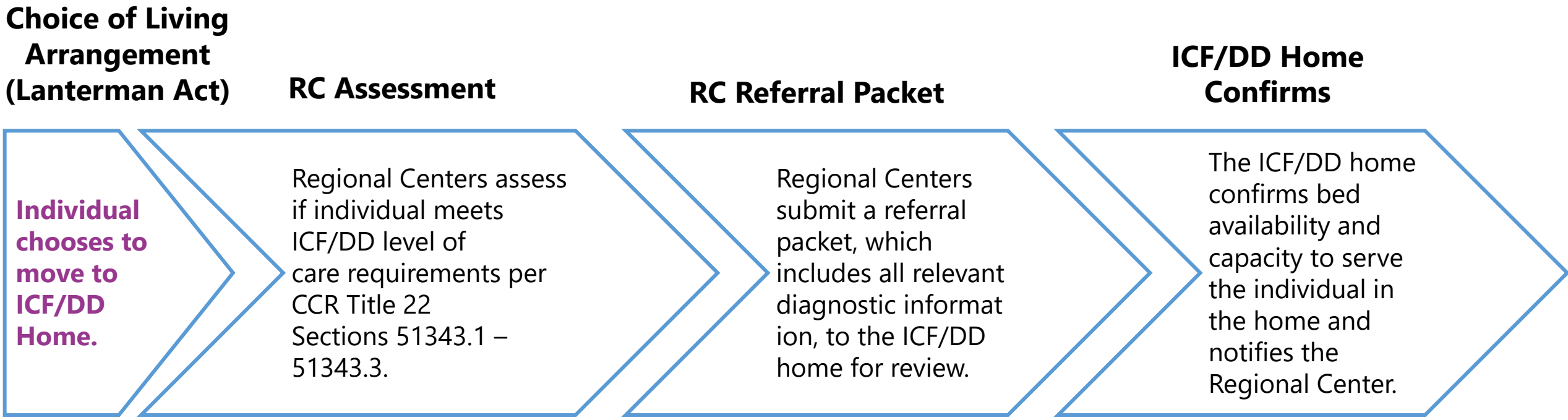
TAR Process Flowchart – *Current*



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.
  - 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

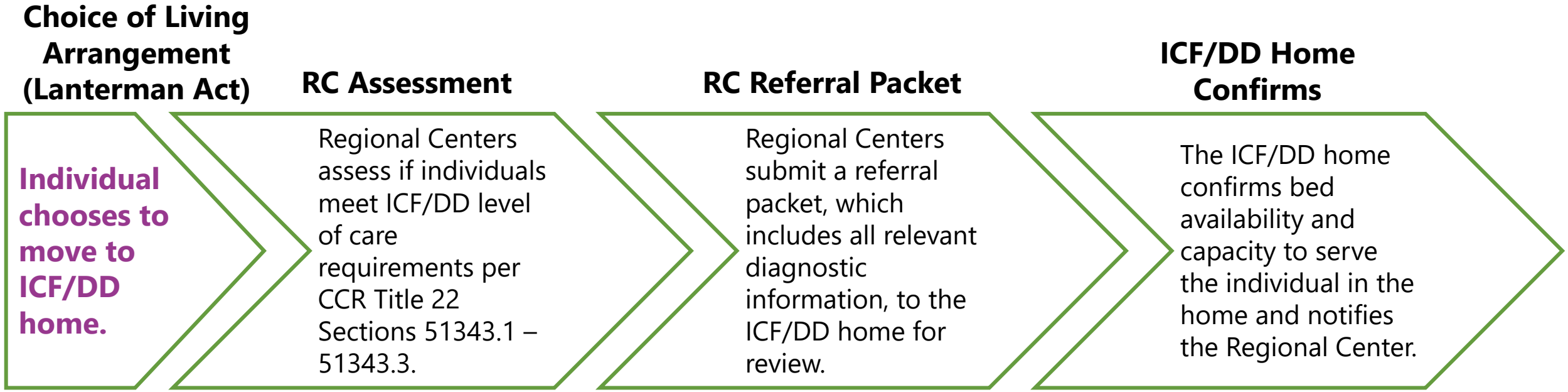
DHCS or COHS Plan reviews the submitted TAR form, HS231 form, 6013A form (or alternative information) and any attached documentation showing medical necessity, current care needs, and recipient prognosis, and makes a medical necessity determination and authorization decision (approval or denial).

Authorization Communicated to ICF/DD Home

The authorization decision is communicated 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*

The same forms will be used 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.
  - 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).

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 authorization decision is communicated to the ICF/DD home.

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).

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Individual Program Plan (IPP) and Individual Service Plan (ISP)

Regional Center IPP	
The individual is the director of their IPP and the IPP is the master plan for all services and supports.	Written plan developed by the RC service coordinator, individual, and anyone the individual chooses to include in planning.
A person-centered plan that helps identify and plan how a person with an intellectual or other developmental disabilities will choose and receive services and supports, including where to live.	Contains approximate scheduled start dates and timeline for actions necessary to begin services and supports, the type and amount of services and supports the RC will purchase or that will otherwise be obtained, and a list of parties responsible for providing services and supports.
ICF/DD Home ISP/IPP Title 42, Chapter IV, Subchapter C, Part 456, Subpart F & Subpart I	
Written plan sent to the State, developed jointly with individual and anyone the individual chooses to include in planning, based on the comprehensive functional assessment.	Must be developed within 30 days of admission; reviewed at least annually.
An ISP is a working plan that outlines the ways by which a provider, including an ICF/DD home, assists the person to attain his/her personal goals, as defined in the person's IPP.	Includes the active treatment (AT) goals, objectives, and methodology.

How will MCPs and RCs coordinate their different care management responsibilities for RC clients, including those in ICF/DD homes?

- Current Practices: This will be a new process as part of the ICF/DD carve-in.

Current COHS Plans Process

COHS Plans pay for ICF/DD home services and coordinate other medical service needs.

- Recommendations: No changes are recommended for the RC or ICF/DD homes' role in individual planning. Working with the beneficiary, the RC will create the IPP, and the ICF/DD home will create the ISP within 30 days of the individual moving in and provide a copy to the MCP.
- DHCS views the MCP care manager as another resource for the interdisciplinary team. MCP involvement should help to address a Member's individual, person-centered needs.
- **ICF/DD Homes are not Medicare Providers and the per diem is not Medicare eligible. There will be no changes to the member's Medicare coverage as a result of the ICF/DD carve-in.**

How will MCPs and RCs coordinate their different care management responsibilities for RC clients, including those in ICF/DD homes?

- For Members who are dually Medicare and Medi-Cal covered, or who happen to have other healthcare coverage (OHC), the MCP must coordinate care and address coverage needs, regardless of payor source.
- **Feedback Incorporated:** DHCS has heard feedback that any additional participation by the MCP care manager in the Members' IPP or other services/supports planning should have a value-add and not be disruptive to the Member or their home.
- In order to effectively understand the needs of the Members living in ICF/DD homes, the ICF/DD model of care, the person-centered planning approach, the mandate and benefits of active treatment, and to help with filling in care management gaps, the MCP should establish an effective communication strategy with the ICF/DD home and Regional Center case manager to meet the needs of individual Members. This may include attending and participating in IPP meetings, if the planning team, most importantly the Member, feels there is an added value. At minimum, the MCP should have a copy of the IPP/ISP on file such that there is sufficient information to support care management and care coordination.

How will ICF/DD homes, and MCPs when applicable, provide input to the RCs during development of an individual's IPP?

- Current Practices: This will be a new process as part of the ICF/DD carve-in.

Current COHS Plans Process

Current understanding is that in COHS plan counties, the COHS Plans pay for ICF/DD home services but are not involved in other aspects of Members' care planning, including Individual Program Plan (IPP) development or updates.

- Recommendations: No changes are recommended for the RC or ICF/DD homes' role in individual planning. Working with the beneficiary, the RC will create the IPP, and the ICF/DD home will create the ISP within 30 days of the individual moving in and provide a copy to the MCP.
- DHCS views the MCP care manager as another resource for the interdisciplinary team. MCP involvement should help to address a Member's individual, person-centered needs.

How will ICF/DD homes, and MCPs when applicable, provide input to the RCs during development of an individual's IPP?

- **Feedback Incorporated:** DHCS has heard feedback that any additional participation by the MCP care manager in the Members' IPP or other services/supports planning meetings should have a value-add and not be disruptive to the Member or their home.
- In order to effectively understand the needs of the Members living in ICF/DD homes, the ICF/DD model of care, the person-centered planning approach, the mandate and benefits of active treatment, and to help with filling in care management gaps, the MCP should establish an effective communication strategy with the ICF/DD home and Regional Center case manager to meet the needs of individual Members. This may include attending and participating in IPP meetings, if the planning team, most importantly the Member, feels there is an added value.
- At minimum, the MCP should have a copy of the IPP/ISP on file such that there is sufficient information to support care management and care coordination.
  - Examples of how MCP care managers can assist in meeting member's needs: assisting the ICF/DD home or Regional Center with helping a Member get timely access to a healthcare or specialty provider; assisting with securing and sharing healthcare information/records from one treatment setting to another for the purposes of addressing a Member's ongoing healthcare needs; helping a Member and their family with decisions about healthcare resources in another area if they are contemplating moving to another ICF/DD home; etc.

How will the MCP work with RCs and CDPH to raise ICF/DD home concerns?

- Current Practices: The California Department of Public Health (CDPH) already has an established complaint and investigation process (https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/pages/complaintinvestigationprocess.aspx), whereby anyone can file a complaint against a healthcare facility or provider.
- In addition, complaints may be made to the Long Term Care (LTC) Ombudsman (https://aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/). Any concerns can also be directed to the assigned Regional Center.

Current COHS Plans Process

There is no different complaint process specific to COHS plan counties or for Member's whose services are managed by a COHS plan. Complaints may also be reported to the COHS Plan when it pertains to the services or supports received by a COHS Plan member.

How will the MCP work with RCs and CDPH to raise ICF/DD home concerns?

- Established policy: At carve-in, there will be no changes to any of the complaint processes of the Regional Centers, CDPH, or the LTC Ombudsman.
- There will be no changes to how the ICF/DD homes work with the Regional Centers or CDPH.
- For minor concerns or issues, the ICF/DD home QIDP or administrator can be informed of the observed issue so that they can address or clarify any misunderstanding and/or make necessary changes. However, this would not supplant any mandated reporting required by law or other policy.
- It is expected that any observed quality of care issues or concerns about abuse, neglect, or exploitation be handled according to established policy and State law.
- **Feedback Incorporated:** DHCS will make clear in the APL that any existing laws and policies regarding complaints against ICF/DD homes still apply and are not being changed as a result of the ICF/DD carve-in to managed care.

How will MCPs submit referrals to RCs when an individual is referred for ICF/DD placement?

- Current Practices: Regardless of the point of initiation, all ICF/DD, ICF/DD-H, and ICF/DD-N home placements are managed by the Regional Centers. Living in an ICF/DD home is a choice individuals make about where to live (Lanterman Act).
- The Regional Centers then assess if individuals meets ICF/DD level of care requirements consistent with CCR Title 22, Sections 51343.1 - 51343.3 and submit a referral packet, which includes all relevant diagnostic information, to the ICF/DD home.

Current COHS Plans Process

Any ICF/DD home placement requests or inquiries that come directly to the COHS Plans are referred to the coordinating Regional Center for review and processing.

How will MCPs submit referrals to RCs when an individual is referred for ICF/DD placement?

- Recommendations: Effective at carve-in, there will be no changes to the ICF/DD home placement process or role of the Regional Centers.
- **Feedback Incorporated:** Any ICF/DD placement referrals, inquiries, or requests should be referred to the coordination/assigned Regional Center based on the Member's location for review and processing. This includes any referrals initiated by an MCP.

Scenario 1 – Floyd

- Floyd is a 51-year-old man who has lived in the Big Sky Home (ICF/DD) for the past 8 years. Floyd has been receiving services through the Wide River Regional Center.
- Staff in the Big Sky Home observe that Floyd's scoliosis and kyphosis appear to be worsening, and that Floyd is becoming increasingly agitated and moody, likely due to his discomfort. They feel Floyd needs to see an orthopedist to determine if he needs any new interventions to manage his condition, but the doctor Floyd has seen in the past has moved away. Floyd's home staff and Regional Center case manager have not been able to find an orthopedist nearby who is willing to assess Floyd and they are concerned that a long drive to such an appointment will further exacerbate Floyd's pain, leading to agitation and aggression.
- Floyd is now a part of the PCH Plan. Floyd's Regional Center service coordinator reaches out to his PCH Plan care manager to see if the plan has any recommendations for an orthopedist within a one-hour drive from the home who will be willing to see Floyd. Floyd's plan care manager informs his Regional Center service coordinator that they can connect Floyd to an orthopedist within their network who has privileges at a hospital only 25 minutes from the Big Sky Home.

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Population Health Management Program Overview

DHCS is establishing a standardized, statewide approach to PHM through which Medi-Cal Managed Care Plans (MCPs) are responsive to community needs and work within a common framework to improve outcomes and reduce disparities.

PHM Program Overview

- A cornerstone of CalAIM includes the expectation that starting in 2023, each Medi-Cal MCP will **have and maintain a whole system, person centered Population Health Management** (PHM) program.
- Many of the **key elements of PHM are already in place** in Medi-Cal through both Department of Health Care Services (DHCS) policies and each Medi-Cal MCPs' population health management programs.
- **The PHM Program is a cohesive set of concepts and requirements that apply to all populations served by Medi-Cal MCPs**.

Beginning in 2023, all Medi-Cal MCPs will be required to meet National Committee for Quality Assurance (NCQA) PHM standards.

PHM requirements will be phased in, and DHCS will **roll out new PHM requirements gradually between 2023 and 2024**.

CalAIM Care Management Continuum

In 2023, Medi-Cal managed care plans (MCPs) are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** Medi-Cal MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are supports and services for members transferring from one setting or level of care to another.

For more information on the CalAIM Care Management continuum, see the PHM Policy Guide

Overview of BPHM

BPHM means an approach to care that ensures needed programs and supports are made available to each Member, at the right time and in the right setting to address their health and health-related needs.

BPHM Defined

The Key components of BPHM include:

- **Access, utilization, and engagement with primary care**
- **Care coordination and referrals to all health and social services**
- **Information sharing and referral infrastructure**
- **Integration of Community Health Workers (CHW)**
- **Wellness and prevention programs**
- **Programs addressing chronic disease**
- **Program to address maternal health outcomes**
- **PHM for children, including ensuring Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for all children and youth**

The components of BPHM are not new, and many are included in NCQA PHM standards; however, DHCS has not previously articulated them as a comprehensive a package of programs and supports.

Overview of Complex Care Management

DHCS is establishing common terminology and set of expectations that apply across populations who need care management, establishing a continuum between care management approaches, including CCM and ECM.

Complex Care Management

- Equates to "Complex Case Management" as defined by NCQA.
- For both higher and medium/rising-risk Members.
- Includes chronic care management and interventions for episodic, temporary needs.
- Must include comprehensive assessment and adhere to all NCQA PHM CCM requirements.
- Medi-Cal MCPs may use their own staff as care managers.

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- ECM is part of broader CalAIM Population Health Management system design through which Medi-Cal MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

For more details, see ECM Policy Guide (December 2022).

Seven ECM Core Services

Outreach and Engagement

Member and Family Supports

Comprehensive Assessment and Care Management Plan

Health Promotion

Enhanced Coordination of Care

Comprehensive Transitional Care

Coordination of and Referral to Community and Social Support Services

Individuals with Developmental Needs

- As of December 2022, DHCS is defining "individuals with I/DD" as a freestanding ECM Population of Focus, to focus attention and care on strengthening care management with this population and to encourage MCPs to develop networks of ECM Providers with special expertise service individuals with I/DD.
- Individuals receiving 1915(c) waiver services and those residing in ICF/DD homes are not eligible for ECM (see Section VI. Program Overlaps and Exclusions).
- This Population of Focus will go live July 2023.
- ECM Policy Guide:

Population of Focus Eligibility Criteria

Adults with an I/DD are adults who:

- 1) Have a diagnosed I/DD; AND
- 2) Qualify for eligibility in any other adult ECM Population of Focus.

Children and Youth with an I/DD are children and youth who:

- 1) Have a diagnosed I/DD; AND
- 2) Qualify for eligibility in any other children and youth ECM Population of Focus.

Will individuals residing in ICF/DD homes be eligible for Enhanced Care Management (ECM)?

- Current Practices: The changes in the CalAIM Population Health Management (PHM) requirements are new and continuing to develop.

Current COHS Plans Process

COHS plans provide care management, but do not duplicate existing ICF/DD home or Regional Center services.

- Recommendation: MCPs must implement a Population Health Management (PHM) Program that ensures all Medi-Cal managed care Members, including those using ICF/DD home services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), transitional care services (TCS), care management programs, and Community Supports.
- Care management is focused on populations with significant or emerging needs, all MCP Members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

Will individuals residing in ICF/DD homes be eligible for Enhanced Care Management (ECM)?

- People living in ICF/DD homes are not currently eligible for Enhanced Care Management (ECM), as care management is part of the ICF/DD model, and they receive additional case management from the Regional Centers. However, if there are other individual care needs or concerns, the person's needs can be reviewed by the MCP for consideration. If a member will be transitioning out of an ICF/DD home, the restriction of duplicative services is removed, and the person's needs will need to be reviewed by the MCP to determine the need and eligibility for ECM.
- Regional Center and ICF/DD Home service coordination and case management will continue unchanged. They will be working with new partners – the MCPs.
- **Feedback Incorporated:** To prevent duplication of services, MCPs will be required to provide Basic Population Health Management (BPHM) services, transitional care services (TCS), and Complex Care Management (CCM) services to people living in ICF/DD homes. This will include filling in any additional care need gaps the member has that are not already met or expected to be met by the ICF/DD home or Regional Center.

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What are the bed hold policies for ICF/DD homes?

- Current Practices: For people living in an ICF/DD home, a bed hold is allowed for up to 7 days for each episode of acute hospitalization (Title 22, 51535.1, *Bed Hold for Acute Hospitalization*). Upon transfer to a general acute care hospital, the client or the client's representative notifies the ICF/DD home if the client desires the bed hold.

Current COHS Plans Process

Once admitted to an acute care hospital, the ICF/DD home notifies the COHS plan that the member is hospitalized and if a bed hold is needed.

- Established policy (LOA, Bed Hold, and Room and Board): Bed holds should be honored per existing law. In order to minimize any disruption in the individual's life, they should be permitted to return to their home, provided that the ICF/DD home continues to meet the individual's level of care and services and supports needs.
  - Requirements regarding leave of absence, bed hold, and continuity of care policies apply.

What are the bed hold policies for ICF/DD homes?

- The MCP must have processes in place for monitoring the member's bed hold usage and communicating those days with the ICF/DD homes, including tracking of payments accordingly.
- DHCS has asked the MCPs and ICF/DD homes to identify points-of-contact to help create communication channels to address needs such as payment questions, contracting, claims processes, etc.
- **Feedback Incorporated:** DHCS will make clear in the APL that the MCP's are responsible for monitoring each member's bed holds and communicating clearly with the ICF/DD homes. Specifically, that the MCP must have processes in place for monitoring the member's bed hold usage and communicating those days with the homes, including tracking of payments accordingly.

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Future Meetings

- **Additional meetings for March and April will be scheduled soon.**
- Information related to the ICF/DD Carve-In and links to the Stakeholder Workgroups can be found at:

  Intermediate-Care-Facility-for-Developmentally-Disabled-ICF-DD-Long-Term-Care-Carve-In

Appendix

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

Policy Questions/Issues Timeline

Category	Policy Questions	Workgroup Review Timeline
Authorizations and Continuity of Care	• What continuity of care protections will be in place for ICF/DD residents? (homes)	December 2022
	• What continuity of care protections will be in place for ICF/DD residents? (providers)	
	• What continuity of care protections will be in place for active authorizations?	
	• What are the hospice policies for ICF/DD homes?	
	• What are the bed hold policies?*	
	• What will be the process and timeframes for ICF/DD home service authorizations?	
	• What will be the process and timeframes for service authorizations?	
	• Will there be any changes to services provided by the ICF/DD homes or Regional Centers?	

Policy Questions/Issues Timeline

Category	Policy Questions	Workgroup Review Timeline
Payments and Rates	• What is the process by which ICF/DD homes will be paid?	January 2023
	• How will rates be set for ICF/DD homes?	
Leaves of Absence (LOA)	• What are the leave of absence policies?	
Member & Provider Communication	• How will individuals be notified of the ICF/DD carve-in (member noticing)? • How will providers (homes) be notified of the ICF/DD carve in?	
Data Sharing	• What basic data sharing is needed among MCPs/RC/and Homes?	
	• What data will DHCS need to share with MCPs to affect a smooth member transition?	
Credentialing and Networks	• How can MCPs engage with ICF/DD homes for contracting?	
	• How will ICF/DD homes and contracted/consulting providers be enrolled and credentialed with the MCPs?	
	• What are DHCS' network adequacy requirements for MCPs pertaining to ICF/DD homes?	

Policy Questions/Issues Timeline

Category	Policy Questions	Workgroup Review Timeline
Complaint Resolution	• What is the member complaint resolution process (appeals and grievances)? • What is the process for complaint resolution (resolution of disagreements among MCPs, ICF/DD homes, and Regional Centers)?	March 2023

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 All Plan Letter (APL) focused on the ICF/DD carve-in.

Project Timeline

Milestones	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
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**	1/20	2/10	TBD	TBD									
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, continued

Milestones	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
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 and data sharing.													
Target date to issue Draft APL for public comment.			★										
Educational Webinars (Provider-facing trainings; MCP-facing trainings)													
Issue final APL.										★			

Carve-In Go-Live

ICF/DD Planning and Policy Committee

Name	Organization	Name	Organization
Amy Westling	Association of Regional Center Agencies	Linnea Koopmans	Local Health Plans of CA
Karen Widerynski	CA Association of Health Facilities	Stacy Sullivan	Mountain Shadows Support Group
Kate Ross	CA Association of Health Plans	Lori Anderson	Momentum
Martha Santana-Chin Edward Mariscal	HealthNet	Larry Landauer	Regional Center of Orange County
Helen Bayerian	Health Plan of San Joaquin	Olivia Funaro	San Gabriel/Pomona Regional Center
Brian Tremain	Inland Regional Center	Mark Klaus	San Diego Regional Center
Becky Joseph	JonBec Care Inc.	Deb Donovan	Valley Village
		Diane Van Maren	Developmental Services Network

Scenario 2 – Roberto

- Roberto is a 56-year-old man who has lived in the Grand Sequoia Home (ICF/DD) for the past 14 years. Roberto has been receiving services through the Tall Mountain Regional Center. Over the past couple of years, Roberto has increased episodes of aspiration and has required a few hospitalizations after developing aspiration pneumonia.
- Roberto's family and interdisciplinary team feel Roberto needs a new swallowing evaluation, but his long-time Speech-Language Pathologist recently retired, and his home staff and Regional Center service coordinator have not been able to find a SLP who is willing to come to the home to assess Roberto. Roberto gets very anxious when leaving home to attend medical appointments, often requiring sedation, which affects the ability to evaluate his swallowing.
- Roberto is now a member of the Stellar Care Plan. Roberto's Regional Center service coordinator reaches out to his Stellar Care Plan care manager to see if the plan has any recommendations for a SLP who can come to the home to assess Roberto's swallowing needs. The plan care manager informs Roberto's team that, due to his increased medical needs, they will authorize an SLP in a neighboring county to travel over to Grand Sequoia Home to assess and serve Roberto.

Scenario 3 – Brenda

- Brenda is a 72-year-old woman who has lived in the Wise Owl Home for the past 32 years. In addition to a diagnosis of profound Intellectual Disability, Brenda is also diagnosed with spastic quadriplegia. Brenda has been receiving services through the Deep Valley Regional Center. Over the past 2 years, Brenda has been less mobile and has increased pressure sores which have been difficult to heal, resulting in pain which increases agitation and aggression with staff when they clean her wounds. She has required frequent hospitalizations and stepdown care before being able to return to her home.
- Following hospitalizations, the home staff has not been able to get complete records from her hospitalizations. The QIDP has tried to get records, but the discharge summaries do not provide enough detail regarding what treatments were most effective during her hospital/stepdown stays.
- Brenda is now a part of the Elevation Managed Care Plan. The plan care manager can now assist with getting the information needed to continue Brenda's care and pass those along to the Wise Owl Home staff.

Glossary

Term	Definition
APL	All Plan Letter
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
DDS	Department of Developmental Services
DHCS	Department of Health Care Services
DSN	Developmental Services Network - An ICF services trade association

Glossary (cont,)

Term	Definition
FFS	Fee for Service
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for Developmentally Disabled
ICF/DD-N	Intermediate Care Facility for Developmentally Disabled-Nursing
ICF/DD-H	Intermediate Care Facility for Developmentally Disabled-Habilitative
IPP	Individual Program Plan
ISP	Individual Service Plan
LHPC	Local Health Plans of California
LOA	Leave of Absence
LTC	Long Term Care
MCP	Managed Care Plan
Medi-Cal	California's Medicaid Program
NOAI	Notice of Additional Information (in the context of member noticing)
RC(s)	Regional Center(s)
TAR	Treatment Authorization Request