

<b>POLICY AND PROCEDURE</b>	
<b>Policy # and TITLE:</b> UM 90 Intermediate Care Facilities	
<b>Primary Policy owner:</b> Utilization Management	<b>POLICY #:</b> UM 90
<b>Impacted/Secondary policy owner:</b> Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input checked="" type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input checked="" type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Case Management (CM) 5) <input checked="" type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input checked="" type="checkbox"/> Configuration (CFG) 9) <input checked="" type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input checked="" type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input checked="" type="checkbox"/> Information Technology / Core Systems (IT) 16) <input checked="" type="checkbox"/> Pharmacy (PH) 17) <input checked="" type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
<b>PRODUCT TYPE:</b> <input checked="" type="checkbox"/> Medi-Cal	<b>Supersedes Policy Number:</b> N/A

## I. PURPOSE

To outline Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") responsibility to authorize and provide medically necessary services for members residing in or obtaining care in an Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD) Home.

## II. POLICY

- A. Health Plan is responsible for providing all medically necessary covered services for Non-Dual and Dual members residing in or obtaining care in an ICF/DD home, including:
  - 1. Home services,
  - 2. Professional services,
  - 3. Ancillary services, and
  - 4. Transportation services.
- B. These Members' relationship with their Regional Center (RC) shall continue. Access to RC services and to the current Individualized Program Plan (IPP) process shall remain the same.
- C. Health Plan ensures that timely access to the ICF/DD Home benefit is available within five to no more than 14 calendar days of receiving the authorization request form from the ICF/DD Home, according to the county of residence, as outlined in Welfare and Institutions Code (W&I) section 14197.
- D. Health Plan is responsible for providing the appropriate level of care coordination and ensuring members who need ICF services are placed in a healthcare facility that provides the most appropriate level of care (LOC) for the Member's medical needs.
- E. Health Plan ensures Members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. Health Plan must receive a copy of the Certification for Special Treatment Program Services form HS 231 as prerequisite to providing coverage of ICF/DD Home services.
- F. Health Plan is responsible for coordination of benefits with other health coverage (OHC) programs, recognizing OHC as primary, and Medi-Cal as the payer of last resort, in accordance with Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage.
  - 1. OHC providers do not need to be in Health Plan network to continue providing services or billing Health Plan.
  - 2. Health Plan is responsible for care coordination and addressing coverage needs for those members who are dually Medicare and Medi-Cal covered, or who have OHC, in accordance with Health Plan Policies CM66 Case Management Programs, PHM01

Population Health Management and CLMS13 Reimbursement of Services: Claims.

3. LTC ICF/DD is not a Medicare benefit and is exclusively covered by Medi-Cal. However, members may still receive other services from Medicare in addition to the ICF/DD benefits that fall to Health Plan to coordinate.
- G. Health Plan ensures that Network Providers have training on benefits coordination, including balanced billing prohibitions as described in Health Plan Policy PRO20 Provider Training and Education.
- H. Health Plan provides Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to Members, including those residing in an ICF/DD Home, in accordance with APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, and Health Plan Policies UM 55: Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses and CS21: Non Medical Transportation.
1. For covered services requiring recurring appointments, Health Plan provides authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months.
  2. For NEMT services, the Member must have a valid Physician Certification Statement form authorizing NEMT by the Provider.
  3. Day programs and associated transportation continues to be provided by the ICF/DD Home and are not the responsibility of Health Plan.
- I. Responsibility for medications for members residing in an ICF/DD home is outlined in Health Plan policy PH30 Medical vs. Pharmacy Benefit. Health Plan is responsible for the coordination of medically necessary drugs or medications on behalf of the member.
- J. Health Plan must cover the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then requires a return to an ICF/DD Home.
- K. Health Plan allows Members to return to the same ICF/DD Home where they previously resided, if it is the Member's preference, in accordance with Medi-Cal leave of absence/bed hold policies.
1. Health Plan includes as a covered benefit any leave of absence

- (LOA) or bed hold that the ICF/DD Home provides.
- a. Health Plan authorizes up to 73 days per calendar year for an LOA.
  - b. Health Plan authorizes up to a total of seven days of bed hold per hospitalization.
2. Health Plan ensures that the ICF/DD Home notifies the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision.
  3. A physician's signature is required for an LOA only when the member participates in summer camp for the developmentally disabled.
  4. The Bed Hold must be held vacant during the entire hold period, maximum of seven (7) days for each Bed Hold period.
  5. If notified in writing by the attending physician that the member requires more than seven (7) days of hospitalization, the ICF/DD home is not required to hold the bed.
  6. If the Member does not wish to return to the same ICF/DD Home following an approved LOA or bed hold period, Health Plan provides care coordination and transition support. Health Plan works with the assigned RC to assist the member in finding a another ICF/DD Home within Health Plan's network that can serve the member.
    - a. The RC takes the lead on discharge and transition planning if the Member wishes to transition to an RC-funded living situation with input from other stakeholders such as the hospital, the original ICF/DD home, and Health Plan.
    - b. Health Plan takes the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care (LOC).
- L. Members residing in an ICF/DD Home and newly enrolled in Health Plan may request continuity of care in accordance with Health Plan Policy CM69 Continuity of Care.
- M. In accordance with Health Plan Policy UM 01 Authorization and Referral Process, routine authorizations are subject to a five-day turnaround time.

- N. ICF/DD Homes submit the Certification for Special Treatment Program Services HS 231 to Health Plan with any initial or reauthorization requests.
1. Health Plan accepts the Certification for Special Treatment Program Services form HS 231 as evidence of the RC's determination that the Member meets the ICF/DD Home level of care.
  2. IPP submissions are required as part of the periodic review of ICF/DD-N Homes.
  3. In situations where the member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated authorization request that includes the changed date of service.
- O. Health Plan and ICF/DD Homes are required to follow the Medi-Cal Provider Manual and statutory and regulatory requirements related to LTC services for ICF/DD Home services.
- P. Health Plan is required to coordinate and work with the RC in the identification of the services that are provided to the member by Health Plan, to ensure reduction in duplication of effort on work amongst Health Plan and RCs.
1. Work with the RCs is done to ensure Health Plan is fully aware of the Member's needs and the services to be provided by both parties.
  2. It is the RC's duty to ensure their members residing in ICF/DD Homes receive all services and support identified in the IPPs.
  3. Health Plan informs the RC which services shall be provided to the member.
    - a. A Memorandum of Understanding between Health Plan and RCs that includes coordination for Members living in the ICF/DD supports this effort.
- Q. Health Plan is responsible for providing Population Health Management (PHM) services to Members residing in ICF/DD Homes, ensuring access to a comprehensive set of services based on their needs and preferences across the continuum of care, in accordance with Health Plan Policies PHM01 Population Health Management, CM66 Case

Management Programs, CM73 Enhanced Care Management, UM50 Community Supports and UM88 Transitional Care Services, including:

1. Coordination of medically necessary drugs or medications on behalf of the Member,
  2. Basic Population Health Management
  3. Transitional Care Services,
  4. Care Management Programs, and
  5. Community Supports.
    - a. These services are provided to ICF/DD Home members as appropriate and in accordance with their RC.
- R. Quality monitoring and reporting are done to monitor quality and appropriateness of care provided to members who reside at ICF/DD Homes through the establishment of the ICF/DD Home's quality assurance program.
1. Health Plan establishes a mechanism to receive the Homes' oversight and compliance findings and data from the California Department of Public Health (CDPH), as well as service delivery findings from the RCs, through Health Plan and RC's executed MOU.
  2. Upon DHCS request, Health Plan submits quality assurance reports with outcome and trending data.
- S. Health Plan identifies an individual, or set of individuals, to serve as a liaison for the long-term Services and Supports (LTSS) Provider community.
1. This role must serve as a single point of contact for the service providers in both a Provider representative role and to support care transitions as needed. This role shall have access to subject matter experts for issues related to:
    - a. Care transitions to best support the member's needs, and
    - b. Assist providers in addressing claims and payment inquiries.
    - c. Health Plan ensures that their contact information is provided to Network Providers and notify them of any changes in the liaisons' assignment as expeditiously in order to ensure coordination of services offered to Members.

2. Liaisons receive training on the full spectrum of rules and regulations pertaining to the services they are coordinating, including referral requirements and processes, care management and authorization processes
3. The LTSS liaison is trained in:
  - a. The rules and regulations pertaining to Medi-Cal covered LTC services, including payment and coverage policies
  - b. Timely claims payment requirements
  - c. The provider dispute resolutions process, and related policies and procedures
  - d. Care management, coordination and care transition policies among the LTSS Provider community to best support Members' needs in relation to LTC services
  - e. Assisting facilities in addressing claims and payment inquiries
  - f. Disseminating their contract information to the plan's providers
  - g. Providers of changes to LTSS liaison assignment expeditiously to ensure coordination and services to members
  - h. Knowing the most appropriate internal plan resources to call on so the liaison can serve as the single point of contact for providers
4. UM provides policies and procedures training in:
  - a. Authorizations and referrals
  - b. Care management
  - c. Care coordination
  - d. Care transitions

## II. PROCEDURE

- A. For new authorization of ICF/DD Home Services for members, or at time of reauthorization, the nurse obtains Certification for Special Treatment Program Services form HS 231 as evidence of the RC's determination that the Member meets the ICF/DD Home level of care to determine medical necessity.
- B. Reauthorizations may be granted for up to two (2) years.
- C. Health Plan is responsible for ensuing care transitions occur as outlined in Health Plan Policy UM 88 Transitional Care Services.

- D. Health Plan monitors over/underutilization of ICF/DD Home services in accordance with Health Plan Policy UM05 Over/Underutilization of Services Monitoring.

### III. ATTACHMENT(S)

- A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- B. [Glossary of Terms Link](#)
- C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

### IV. REFERENCES

- A. 22 California Code of Regulations (CCR) Sections 51303, 51304, 51321(g, h), 51340, 51343.1(e), 51340, 5151151535, 51535.1, 76345 - 76355, 76506, 76817 – 76931, 76301 – 76413, and 51165
- B. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-023: Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- C. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses
- D. Health and Safety Code (H&S) sections 1250(a, e, h, g)
- E. Health Plan Policy CLMS13 Reimbursement of Services: Claims
- F. Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage
- G. Health Plan Policy CM66 Case Management Programs
- H. Health Plan Policy CM69 Continuity of Care
- I. Health Plan Policy CS21 Non Medical Transportation
- J. Health Plan Policy PH05 Prior Authorization Review
- K. Health Plan Policy PH23 Submission of Pharmacy Benefit Prior Authorization & Claims
- L. Health Plan Policy PHM01 Population Health Management
- M. Health Plan Policy PRO20 Provider Training and Education
- N. Health Plan Policy UM01 Authorization and Referral Process.
- O. Health Plan Policy UM05 Over/underutilization of Services Monitoring
- P. Health Plan Policy UM06 Medical Review Criteria

- Q. Health Plan Policy UM07 Notification to Members of Denial, Deferral, and Modification Actions
- R. Health Plan Policy UM40 Dental Services
- S. Health Plan Policy UM50 Community Supports
- T. Health Plan Policy CM73 Enhanced Care Management
- U. Health Plan Policy UM88 Transitional Care Services
- V. Welfare and Institutions Code(W&I) section 14197, 4512

**V. REVISION HISTORY**

*\*Version 001 as of 01/01/2023*

<b>Version*</b>	<b>Revision Summary</b>	<b>Date</b>
001	Policy developed per DHCS APL 23-023	11/9/2023
002	Updated to include bed hold and LOA requirements for summer camp for DD members, as well as TAR/Authorization Requirements in alignment with LTC Phase II deliverables	1/23/2024
003	Revised LOA/bed hold verbiage, revised Liaison verbiage, grammar changes, corrected ECM policy number, revised referenced policies	3/26/2025
004	Revised the LTSS liaison information and removed automatic CoC verbiage, updated to address DHCS MOR.0248	10/14/2025
<b>Initial Effective Date:</b> 11/1/2023		

**VI. Committee Review and Approval**

<b>Committee Name</b>	<b>Version</b>	<b>Date</b>
Compliance Committee	004	12/02/2025
<ul style="list-style-type: none"> <li>• Privacy &amp; Security Oversight Committee (PSOC)</li> </ul>		
<ul style="list-style-type: none"> <li>• Program Integrity Committee</li> </ul>		
<ul style="list-style-type: none"> <li>• Audits &amp; Oversight Committee</li> </ul>		

<ul style="list-style-type: none"> <li>• Policy Review</li> </ul>	002	3/20/2024
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> <li>• Quality Operations Committee</li> </ul>		
<ul style="list-style-type: none"> <li>• Grievance</li> </ul>		

**VII. REGULATORY AGENCY APPROVALS**

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	004	11/4/2025
Department of Managed Care (DMHC)			

**VIII. Approval signature\***

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

\*Signatures are on file, will not be on the published copy