Policy:	GG.1802
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 01/09/2025*
Effective Date:	06/01/1998
Revised Date:	11/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the criteria for a Member's admission to, continued stay in, or discharge from an Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N), and the requirements for reviewing and processing ICF/DD, ICF/DD-H and ICF/DD-N Notification Forms.

II. POLICY

A. All admissions requiring ICF/DD, ICF/DD-H, or ICF/DD-N levels of service are subject to certification by the Regional Center and the attending physician for placement of all developmentally disabled Members.

B. Regional Centers shall determine the facility placement and level of care for a developmentally disabled Member.

1. Regional Centers must maintain a system to conduct intake, assessment, eligibility determination, person-centered planning, case management, and the purchase of necessary services and supports for eligible individuals.

2. Regional Centers shall develop, purchase, and coordinate the services in each person's Individualized Program Plan (IPP).

C. An Individual Service Plan (ISP) shall be developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the individual, direct care staff, and should include all relevant staff of other agencies involved serving the individual.

1. The ISP shall implement the requirements of the Regional Center's IPP and shall be based on a detailed individual developmental assessment which includes disabilities, developmental strengths, and the individual's needs. The ISP shall include active treatment goals.

2. The ISP shall be completed thirty (30) days following a transition to an ICF/DD Home.

D. The initial and reauthorization requests shall be initiated by the ICF/DD, ICF/DD-H and ICF/DD-N facilities. All authorization requests must be submitted with a Certification for Special Treatment Program Services (HS 231) form, as required by the Department of Developmental Services (DDS). All Members must be approved by Regional Center prior to submission of the HS 231 form.

1. CalOptima Health and ICF/DD Homes shall follow the Medi-Cal Provider Manual and statutory and regulatory requirements related to Long-Term Care (LTC) services for ICF/DD Home services.

2. Whenever a reauthorization of ICF/DD-N Home services is requested, the ICF/DD-N Home must submit a copy of the Member's Individual Service Plan (ISP). ISP submissions are required as part of the periodic review of ICF/DD-N homes.

3. In instances 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 dates of service.

E. The CalOptima Health Long Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stays in, or discharge from an ICF/DD, ICF/DD-H, or ICF/DD-N pursuant to the Medi-Cal Provider Manual and Title 22, California Code of Regulations (C.C.R.) sections 51343, 51343.1 and 51343.2, as well as the California Department of Health Care Services (DHCS) standard clinical criteria for level of care.

F. When the Regional Center determines a Member meets ICF/DD, ICF/DD-H, or ICF/DD-N level of care criteria and authorizes up to two (2) years of service, as documented on the HS 231 form, the CalOptima Health LTSS Department shall document the authorization as requested in the Medical Management System and provide an authorization number to the admitting facility.

G. An ICF/DD, ICF/DD-H, and ICF/DD-N shall submit a completed ICF/DD, ICF/DD-H and ICF/DD-N Notification Form (Sections I, II, III) signed by a physician and the HS 231 form signed by Regional Center, within twenty-one (21) calendar days after a Member's admission to the facility.

H. CalOptima Health's LTSS Department will enter a reauthorization into the Medical Management System when an ICF/DD, ICF/DD-H, ICF/DD-N sends the Regional Center-signed HS 231 form with reauthorization information to CalOptima Health. ICF/DD-N will also be required to submit a copy of the Member's ISP.

I. CalOptima Health shall ensure Continuity of Care (CoC) for Members residing in an ICF/DD, ICF/DD-H, ICF/DD-N in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

1. CoC ensures that a Member's ICF/DD Home will not be changed for at least twelve (12) months while CalOptima Health works to bring the ICF/DD Home into its network.

2. CalOptima Health will automatically provide twelve (12) months of CoC for the ICF/DD Home placement of any Member residing in an ICF/DD Home who is mandatorily enrolled into an MCP after January 1, 2024. Automatic CoC means that Members currently residing in an IC/DD Home do not have to request CoC to continue to reside in the ICF/DD home.

3. CalOptima Health will automatically initiate the CoC process prior to the Member's transition to CalOptima Health.

a. CalOptima Health shall determine if Members are eligible for automatic CoC before the transition by identifying the Member's ICF/DD Home residency and pre-existing relationship through historical utilization data or documentation provided by the Department of Health Care Services (DHCS), such as fee for service utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS.

b. While Members must meet medical necessity criteria for ICF/DD services, CoC must be automatically applied. Medical necessity is determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. The HS 231 form is considered sufficient information; however, if documentation is lacking, CalOptima Health shall request additional supporting documents to substantiate medical necessity.

3. CalOptima Health will ensure CoC for Members in a Subacute Facility by honoring treatment authorization requests (TAR) approved by DHCS for the Member enrolled into the MCP.

J. Effective January 1, 2024, CalOptima Health will provide all Medically Necessary Covered Services for Members residing in or obtaining care in an ICF/DD home, including dental services, home services, professional services, ancillary services, transportation services, and standing referrals, in accordance with CalOptima Health Policies GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center, GG.1504: Dental Services, GG.1505: Transportation: Emergency and Non-Emergency Medical, and GG.1508: Authorization and Processing of Referrals.

K. CalOptima Health will provide access to covered Medically Necessary behavioral health care services in accordance with CalOptima Health Policies GG.1900: Behavioral Health Services and MA.7020: Behavioral Health Services.

L. CalOptima Health will ensure timely provision of access standards, including appropriate clinical timeframes, standards for timely specialty appointments, shortening or expanding timeframes, and arranging timely appointments with a provider shortage, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

M. CalOptima Health will ensure access for disabled Members pursuant to the Americans with Disabilities Act of 1990, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

N. CalOptima Health will provide Medically Necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated provider, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

O. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet Medical Necessity and results in a denial. CalOptima Health's Utilization Management Department will issue the Notice of Action (NOA) to the ICF facility to include information on a Member's appeal rights, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

P. Leave of Absence and Bed Holds

1. CalOptima Health shall cover the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility, or a rehabilitation facility, and then require return to an ICF/DD Home in accordance with CalOptima Health Policy GG.1810: Bed Hold, Long Term Care.

2. CalOptima Health shall cover a leave of absence (LOA) in accordance with CalOptima Health Policy GG.1811: Leave of Absence, Long-Term Care.

    a. If the Member does not wish to return to the same ICF/DD Home following an LOA or approved bed hold period, CalOptima Health shall provide care coordination and transition support, including working with the assigned Regional Center, in order to assist the Member to identify another ICF/DD Home within the CalOptima Health, Health Network.

    b. The Regional Center will take the lead on discharge and transition planning if the Member wishes to transition to a Regional Center funded situation, with input from other stakeholders such as the hospital, the original ICF/DD Home, and CalOptima Health.

    c. CalOptima Health will take the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care.

Q. Population Health Management (PHM) Requirements

1. The Regional Center service coordinator assists the Member and their family members in identifying needs and assessing services and resources, including from other agencies, including generic services when applicable. The service coordinator is the primary person interacting with the Member and is the person ensuring the Member receives the services identified in the IPP.

2. Effective January 1, 2024, CalOptima Health will coordinate and work with the Regional Centers in the identification of services that will be provided to the Member by CalOptima Health in accordance with the Memorandum of Understanding between CalOptima Health and the Regional Center of Orange County.

    a. The goal is to reduce any duplication of effort or work among CalOptima Health and Regional Centers, and to ensure CalOptima Health is fully aware of the Member's needs and the services to be provided by CalOptima Health and Regional Centers.

    b. It is the Regional Center's duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPP.

    c. CalOptima Health shall inform the Regional Centers of which services will be provided by CalOptima Health.

3. Effective January 1, 2024, CalOptima Health shall implement a PHM program ensuring all Medi-Cal managed care Members, including Members living in ICF/DD Homes, have access to a comprehensive set of services based on their needs and preferences across the continuum of care in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).

R. CalOptima Health shall maintain a set of individuals as part of the CalOptima Health Provider Relations Department to serve as the liaison for LTC facilities.

1. Liaisons shall receive training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, provider resolution policies and procedures, and care management coordination and transition policies.

2. LTSS liaisons shall assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS provider community to best support Member's needs.

3. CalOptima Health shall identify these individuals and disseminate their contact information to relevant network providers, including Skilled Nursing Facilities (SNFs) that are within the network.

III. PROCEDURE

A. ICF/DD, ICF/DD-H, and ICF/DD-N facilities shall initiate authorization requests and submit the HS 231 form, signed by the Regional Center Director, to the CalOptima Health LTSS Department to document the authorization as requested in the Medical Management System, and provide an authorization number to the admitting facility.

B. If the ICF/DD, ICF/DD-H and ICF/DD-N Notification Form and the HS 231 forms required attachments are incomplete or not signed as required, the CalOptima Health LTSS Department shall request the facility resubmit completed required documentation.

C. The CalOptima Health LTSS Department will ensure that timely access to the ICF/DD Home benefit is available within five (5) working days to no more than fourteen (14) calendar days of receiving the authorization request from the ICF/DD Home, according to the county of residence.

D. Upon notification by the facility of a Member's discharge, the CalOptima Health LTSS Department shall close the active authorization effective the day of discharge. The facility shall notify CalOptima Health within twenty-four (24) hours of a Member's discharge by submitting the Discharge Disposition Form.

E. Share of Cost (SOC) Spending

1. An ICF/DD, ICF/DD-H, or ICF/DD-N shall be responsible for:

a. Performing an eligibility verification each month for CalOptima Health Member who is residing in the ICF facility;

b. Performing SOC clearance transactions when a CalOptima Health Member with an unmet SOC is admitted, or SOC exceeds the total charges of the contracted rate for a given month's stay;

c. Billing CalOptima Health's Member for the entire SOC if the CalOptima Health Member has not spent any of the SOC in the month's stay; and

d. Maintaining the physician's prescriptions for SOC expenditures in CalOptima Health's Member's medical record.

E. Transitional Care Services (TCS)

1. The CalOptima Health LTSS Department shall provide transitional care services for ICF/DD Members transferring from one setting or level of care to another, in accordance with CalOptima Health Policies GG.1357: Population Health Management Transitional Care Services (TCS) and GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care.

2. CalOptima Health shall ensure that prior authorization determinations are rendered in a timely manner for all Members, including ICF/DD.

3. CalOptima Health shall ensure TCS care managers are notified within twenty-four (24) hours when Members are admitted and discharged from LTC or transferred between facilities. LTC Nursing Facilities/ICF/DD Homes will notify CalOptima Health through the Provider Portal to the LTSS Department.

4. The CalOptima Health LTSS Department shall identify a care manager as a single point of contact for ensuring completion of all transitional care management services, including follow-up after discharge from LTC.

5. Members living in ICF/DD Homes are eligible for basic PHM, TCS and Targeted Case Management (TCM) as applicable.

6. While they are not currently eligible for Enhanced Care Management (ECM), if there are other individual care needs or concerns, their needs can be reviewed for consideration.

7. If a Member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the Member shall be accessed to determine need/eligibility for ECM services.

8. A Member can receive appropriate Community Supports if they are eligible for specific Community Supports that CalOptima Health offers.

9. TCS are generally not duplicative of Community Supports but CalOptima Health shall ensure there is no duplication of services and/or payment.

IV. ATTACHMENT(S)

A. ICF/DD, ICF/DD-H and ICF/DD-N Notification Form
B. Discharge Disposition Form

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
C. CalOptima Health Policy GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center.
D. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services

E. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).
F. CalOptima Health Policy GG.1504: Dental Services
G. CalOptima Health Policy GG.1505: Transportation: Emergency and Non-Emergency Medical
H. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
I. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Health Policy GG.1600: Access and Availability Standards.
K. CalOptima Health Policy GG.1810: Bed Hold, Long Term Care
L. CalOptima Health Policy GG.1811: Leave of Absence, Long-Term Care
M. CalOptima Health Policy GG.1822: Process for Transitioning CalOptima Health Members between Levels of Care
N. CalOptima Health Policy GG.1900: Behavioral Health Services
O. CalOptima Health Policy MA.7020: Behavioral Health Services
P. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
Q. Medi-Cal Long Term Care Provider Manual, Section, Utilization Review: ICF/DD, ICF/DD-H, ICF/DD-N Facilities
R. Memorandum of Understanding (MOU) with the Regional Center - dated 11/10/2011
S. Title 22, California Code of Regulations (C.C.R.), §§ 51003(e), 51118, 51120, 51120.5, 51212, 51121, 51124.5, 51124.6, 51334, 51335, 51335.5, 51335.6, 51343, 51343.1, 51343.2, 76000, 76079, 76345, and 76853
T. Welfare and Institutions Code, §§ 14087.55,14087.6, 14087.95, 14103.6, and 14197

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/03/2015	Department of Health Care Services (DHCS)	Approved as Submitted
01/17/2023	Department of Health Care Services (DHCS)	60 Days No Response
01/07/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/01/2002	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	02/01/2007	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	07/01/2015	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2016	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	06/01/2017	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	12/03/2020	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	08/01/2021	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	08/01/2022	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	10/01/2023	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal OneCare
Revised	09/01/2024	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal OneCare
Revised	11/01/2024	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.
Continuity of Care (CoC)	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management

Term	Definition
	Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Developmental Disability (DD)	A disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the Title 17 CCR § 54000.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systemic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. ECM is a Medi-Cal benefit.
Individualized Program Plan (IPP)	An IPP serves as a contract between the Regional Center and an individual and identifies (1) all serves and supports the individual 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 Medi-Cal.
Individual Service Plan (ISP)	Developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the individual, direct care staff, and should include all relevant staff of other agencies involved in serving the individual. 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. It includes active treatment goals.
Intermediate Care Facility (ICF)	A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program.
Intermediate Care Facility/Developmentally Disabled (ICF/DD)	A facility that provides 24-our 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.
Intermediate Care Facility/ Developmentally Disabled –Habilitative (ICF/DD-H)	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.
Intermediate Care Facility/ Developmentally Disabled – Nursing (ICF/DD-N)	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

Term	Definition
	developmental delay that may lead to a developmental disability if not treated.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare (Duals): Means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. OneCare: A beneficiary enrolled in the CalOptima Health OneCare program.
Memorandum of Understanding (MOU)	A formal written agreement between CalOptima Health and local government agencies, county programs, and third-party entities.
Non-Covered Medical Services	Medical services rendered by a non-Medi-Cal provider; or medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima because the service is not considered Medically Necessary.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Population Health Management	A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in

Term	Definition
	care, standardized assessment processes, and holistic care/case management interventions.
Share of Cost (SOC)	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Targeted Case Management (TCM)	Services which assist Medi-Cal Members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Transitional Care Services	Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).