

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET, Room 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1985



April 1, 2011

TO: INTERMEDIATE CARE FACILITIES/DEVELOPMENTALLY
DISABLED ICF/DD, DD-H AND DD-N

SUBJECT: STATE PLAN AMENDMENT EFFECTING ICF/DD, DD-H AND DD-N
PROVIDERS

The Centers for Medicare and Medicaid Services (CMS) has notified the State that formal approval of the state plan amendment affecting ICF/DD, DD-H and DD-N providers will be forthcoming. This state plan amendment (SPA 07-004), known as the ICF-DD SPA, makes changes, retroactive to July 2007, relative to ICF services and the funding and payment of the day and transportation services received by the consumers residing in your facility. This letter is sent to advise you of the upcoming changes.

BACKGROUND:

With the submission of the ICF-DD SPA, the State has been pursuing federal financial participation (FFP) in the funding of the day and related transportation services received by your residents, pursuant to their regional center individual program plan (IPP). In the course of the ensuing discussions between the State and federal government, CMS clarified the changes the State needed to implement for the receipt of FFP.

CMS has agreed that the day and related transportation services are part of the ICF service and payable through a supplemental payment; however, the federal rules allow for only one provider of the ICF service. This means that all the Medicaid funding for the ICF resident must go to, and through, the ICF provider. Last year, the necessary State statutory changes were made (Enclosure D). As now delineated in state law, the regional center will continue to authorize (and pay for) day and transportation services as reflected on the consumer's IPP and will bill the Department of Developmental Services (DDS), on behalf of the ICF provider, the cost of those services.

The new ICF provider and regional center workload associated with these changes is recognized in the State Budget and each entity will be paid a new administrative fee. Regional centers will include in the bill they submit to DDS, on behalf of the ICF, their

"Building Partnerships, Supporting Choices"

ICF Providers
April 1, 2011
Page two

1.5% administrative fee. The payment DDS sends to the ICF provider will include the cost of the consumer's day and transportation services, the regional center administrative fee (1.5%), the administrative fee of 1.5% for the ICF provider and an ICF Quality Assurance Fee (QAF) of 5.5%. The payment to the ICF will be made in two checks. The check for the day and transportation costs will have an accompanying, 'Remittance Advice' document. Likewise, the check for the regional center and ICF administrative fees and QAF will have an accompanying "Remittance Advice" document clearly identifying the amount of payment for the regional center administrative fee, ICF administrative fee and QAF. The "Remittance Advice" documents will include an invoice number that tracks back to the corresponding regional center "ICF Supplemental Services Summary Claim", and the name of the regional center to which the ICF must make payment.

Two payments with accompanying "Remittance Advice" forms are necessary due to the way the funds were budgeted in the larger State Budget.

The law further specifies the action DDS may take in the event an ICF does not forward the payment to the regional center within the 30 day timeline specified in law.

It is important to note that the processing of the supplemental payment for the day and transportation services of regional center consumers residing in your facility is separate and distinct from the system for invoicing and receiving payment from DHCS for your facility services.

WHAT YOU NEED TO DO NOW

The enclosed detailed summary document (Enclosure A) contains two forms that you **need to complete ASAP.** The first form is entitled "*ICF DD SPA Acknowledgement and Authorization Form*", (Enclosure B) and is self explanatory. The second form is the *Payee Data Record Form (Std. 204)*, (Enclosure C). Completion of this form is required as federal (Internal Revenue Service) and state (Franchise Tax Board) tax laws require that prior to making payments to non-governmental vendors, State agencies must have a completed *Payee Data Record Form (Std. 204)* on file. This means DDS will not be able to make payments to you unless we have your completed form on file. Please complete a Payee Data Record Form (Std. 204) for each facility you operate. Also, please be advised that payments will be sent to the address reflected in the box, "Mailing Address" (i.e. Not the facility address).

ICF Providers
April 1, 2011
Page three

Both of these forms must be completed within 5 days of receipt of this correspondence. A return envelope is enclosed for your convenience. If, for some reason you do not use that envelope, please return the forms to the address below:

Dept of Developmental Services
Attn: Ann Gray
Accounting Office (MS-3-7)
1600 9th Street
Sacramento, CA 95814

Enclosure A contains a detailed summary of the changes that are being implemented and will be fully operational upon receipt of the formal ICF-DD SPA approval notice from CMS. You should anticipate that you will shortly begin receiving copies of regional center claim forms for fiscal years 2007-08 and 2008-09. We thank you in advance for your cooperation. Through this SPA, the State will receive millions of federal Medicaid dollars in the delivery of consumer services.

If you have any questions regarding this correspondence, please contact Linda Croslin, Chief, Health Facilities Program Section, Department of Developmental Services, at (916) 654-3688 or by e-mail at lcroslin@dds.ca.gov. We will be developing and posting a Frequently Asked Questions section on the DDS home page at www.dds.ca.gov.

Sincerely,

Original Signed by

RITA WALKER
Deputy Director
Community Operations Division

Enclosures

cc: Regional Centers
ARCA
Vicki Orlich, DHCS

ENCLOSURE A

Detailed Summary of ICF DD SPA related Changes

The day program and related transportation services received by regional center consumers become an ICF service.

ICF providers immediately complete and send to DDS, within 5 days of receipt of this correspondence, the ICF DD SPA acknowledgement and authorization Form.

ICF providers immediately complete and send to DDS a Payee Data Record Form (Std. 204) for each facility they operate.

These services shall be arranged by the regional center, pursuant to the consumer's regional center individual program plan.

The regional center, on behalf of the ICF, will bill DDS, in arrears. The claim will reflect:

1. The reimbursement amount due to the regional center for purchasing day program and related transportation services for consumers on their behalf;
2. The regional center administrative fee (1.5%);
3. The ICF's administrative fee (1.5% of total cost), and;
4. The ICF's Quality Assurance Fee (5.5% of total cost).

Retroactive claiming will occur first. Regional centers will shortly begin forwarding quarterly claims for FY 2007-08 and 2008-09.

The regional center will send the ICF a copy of the two claiming documents it submits to DDS. The first document, entitled, "The ICF Supplemental Services Detail Report" (Attachment A), includes the consumer's name, names of the provider of day and transportation services and the corresponding regional center issued vendor numbers and service and subcodes, month of service, units of service received, service dates (and corresponding dates in ICF residence). The second document, known as, "ICF Supplemental Services Summary Claim" (Attachment B), includes an invoice number (for accounting and tracking purposes), reflects the day and transportation services costs reflected on the "ICF Supplemental Services Detail Report", the regional center administrative fee and a calculation of the ICF administrative fee and quality assurance fee.

The ICF will retain their copies of the claims submitted to DDS, on their behalf.

DDS will review the claim prior to forwarding to the State Controller's Office for processing payment.

DDS (through the State Controller's Office), will pay the ICF the cost of the consumer's day and transportation services, the regional center administrative fee, the ICF administrative fee and the QAF.

ENCLOSURE A

The two payments to the ICF provider, from the State, will each include a "Remittance Advice" document (Attachment C). One payment will be for the day and transportation costs and will be accompanied by a "Remittance Advice" form indicating the name of the regional center to which payment must be made. The second payment will be for the regional center administrative fees, ICF administrative fees and QAF, and will be accompanied by a "Remittance Advice" form clearly delineating the amount of the payment for each of these three (3) items and the regional center to which the regional center administrative fees payment must be made. The "Remittance Advice" documents will include an invoice number corresponding to the associated regional center submitted, "ICF Supplemental Services Summary Claim".

The ICF provider will forward the identified reimbursement amounts for the day treatment and related transportation services purchased on their behalf and the associated regional center administrative fee, received from the State Controller's Office, to the identified regional center within 30 days of receipt. Send payment to the regional center, to the attention of, "Administrator", unless otherwise directed by the regional center. It is important to note on the check, ICF DD SPA Payment" and the corresponding invoice number from the "Remittance Advice" document for which this payment is made.

Failure of an ICF provider to reimburse the regional center, within 30 days of receipt of payment from the Department/State Controller's Office, will result in action outlined in Welfare and Institutions Code§ 14132.925, subd. (d) (1). DDS may recover outstanding amounts by the following methods:

1. Lump sum payment by the provider;
2. Offset against current payments due to provider from the State of California; and/or;
3. Repayment agreement between the provider and the State of California.

The ICF provider may deposit the ICF Administrative Fee.

On a quarterly basis, the ICF must send the QAF to the address below. It is important to note on the check/documents "ICF-DD QAF Program".

Department of Health Care Services
Accounting/Cashiers Unit MS 1101
1501 Capitol Avenue, Suite 71.2048
P. O. Box 997415
Sacramento, CA 95899-7415

The ICF will be required to report the revenue and expenditures related to Adult Day Services and Related Transportation in the DHCS cost report (DHCS 3076(03/11) following the generally accepted accounting principles and rules, CMS Publication 15-1, Welfare and Institutions Code Sections 4646, 4646.5 and 14132.92 and State Plan Amendment (SPA 07-004). These changes are as follows:

ENCLOSURE A

1. On cost report line number 006 include the revenue for ONLY Adult Day Services and Related Transportation.
2. On cost report line number 241 include the cost associated with providing services pertaining ONLY to Adult Day Services and Related Transportation consisting of:
 - a. Direct Adult Day Services cost and Related Transportation costs.
 - b. Regional center's administrative costs associated with making disbursement on behalf of the ICF Provider for Adult Day and Transportation Services.
 - c. ICF's administrative costs for performing duties related to Adult Day Services.
 - d. Quality Assurance Fee paid associated with Adult Day Services and Related Transportation ONLY in accordance with Health and Safety Code 1324.

No Change:

- The regional center IPP continues to be the document that reflects the planning team's decisions regarding the selected providers of the consumer's day and transportation services.
- Regional centers continue to authorize and pay for these services, pursuant to the consumer's IPP.

ENCLOSURE A

ENCLOSURE A
Attachment A

ICF Supplemental Services Detail Report

VENDOR	VENDOR NAME	INV NBR	AUTH NBR	SVC DATE	SERVICE CODE/SUBCD	FROM AND TO DATE	SERVICE TYPE	UNITS	CLAIM AMOUNT
Regional Center Name and Contact:									
SAMPLE RC 1600 8th Street Sacramento CA 95814				RC Contact	916-955-0000				
ICF Name									
ICF 15 5555 JONES DRIVE SOME CITY CA 9555 95555				ICF #: @15555					
				NPJ: 1000001115		1			
UCI# 5550001	CONSUMER 1	SAM	A						
X00002	DAY PROGRAM 2	0173857		07/2007	510	7/1/2007 7/31/2007	Day	21.00	\$1,407.00
X00002	DAY PROGRAM 2	0174389		08/2007	510	8/1/2007 8/31/2007	Day	23.00	\$1,541.00
X00002	DAY PROGRAM 2	0175782		09/2007	510	9/1/2007 9/30/2007	Day	19.00	\$1,273.00
X00003	TRANSPORTATION PRO	0173837		07/2007	880	7/1/2007 7/31/2007	Transportation	21.00	\$210.00
X00003	TRANSPORTATION PRO	0174389		08/2007	880	8/1/2007 8/31/2007	Transportation	23.00	\$230.00
X00003	TRANSPORTATION PRO	0175782		09/2007	880	9/1/2007 9/30/2007	Transportation	19.00	\$290.00
SUMMARY FOR UCI# 5550001 CONSUMER 1				SAM					
						Day		63.00	\$4,221.00
						Transportation		63.00	\$630.00
						Total		126.00	\$4,851.00
UCI# 5550002	CONSUMER 2	SUE	B						
X00001	DAY PROGRAM 1	0173840		07/2007	510	7/1/2007 7/31/2007	Day	10.00	\$683.80
X00001	DAY PROGRAM 1	0174392		08/2007	510	8/1/2007 8/31/2007	Day	23.00	\$1,526.74
X00001	DAY PROGRAM 1	0175786		09/2007	510	9/1/2007 9/30/2007	Day	19.00	\$1,261.22
X00003	TRANSPORTATION PRO	0173837		07/2007	880	7/1/2007 7/31/2007	Transportation	20.00	\$200.00
X00003	TRANSPORTATION PRO	0174389		08/2007	880	8/1/2007 8/31/2007	Transportation	21.00	\$210.00

Tuesday, March 15, 2011

Page 1 of 3

ENCLOSURE A

ENCLOSURE A Attachment A

VENDOR	VENDOR NAME	INV NBR	AUTH NBR	SVC DATE	SERVICE CODE/SUBCD	FROM DATE	AND TO DATE	SERVICE TYPE	UNITS	CLAIM AMOUNT
X00003	TRANSPORTATION PRO	0175782		09/2007	800	8/1/2007	8/30/2007	Transportation	19.00	\$190.00
SUMMARY FOR UCI# 5550002 CONSUMER 2				SUE				Day	52.00	\$3,451.78
								Transportation	60.00	\$600.00
								Total	112.00	\$4,051.78
UCI# 5550003 CONSUMER 3 DAVID				C						
X00001	DAY PROGRAM 1	0173840		07/2007	510	7/1/2007	7/31/2007	Day	21.00	\$1,393.98
X00001	DAY PROGRAM 1	0174392		08/2007	510	8/1/2007	8/31/2007	Day	23.00	\$1,526.74
X00001	DAY PROGRAM 1	0175786		09/2007	510	9/1/2007	9/30/2007	Day	19.00	\$1,261.22
X00003	TRANSPORTATION PRO	0173840		07/2007	880	7/1/2007	7/31/2007	Transportation	21.00	\$210.00
X00003	TRANSPORTATION PRO	0174392		08/2007	880	8/1/2007	8/31/2007	Transportation	23.00	\$230.00
X00003	TRANSPORTATION PRO	0175786		09/2007	880	9/1/2007	9/30/2007	Transportation	19.00	\$190.00
SUMMARY FOR UCI# 5550003 CONSUMER 3				DAVID				Day	63.00	\$4,181.94
								Transportation	63.00	\$630.00
								Total	126.00	\$4,811.94
SUMMARY FOR ICF 15				NPI: 1000001115	1			Day	178.00	\$11,854.70
								Transportation	186.00	\$1,820.00
								Total	364.00	\$13,774.70

ENCLOSURE A

ENCLOSURE A Attachment A

VENDOR	VENDOR NAME	INV NBR	AUTH NBR	SVC DATE	SERVICE CODE/SUBCD	FROM AND TO DATE	SERVICE TYPE	UNITS	CLAIM AMOUNT
GRAND TOTAL:							Day	178.00	\$11,854.70
							Transportation	186.00	\$1,920.09
							Total	364.00	\$13,774.79

ENCLOSURE A
Attachment B

SAMPLE - ICF Supplemental Services Summary Claim INVOICE # 301072007001
Fiscal Year 2007-2008

Line #	Description	Claim Amount
1	Day Programs	\$11,854.70
2	Transportation	\$1,920.00
3	Subtotal:	\$13,774.70
4	Regional Center Admin Fee (1.5% of Line 3)	\$206.62
5	*Subtotal:	\$13,981.32
6	ICF Admin Fee (1.5% of line 5)	\$209.72
7	Quality Assurance Fee	\$825.93

Total Claim For The Period Of 7/1/2007-9/30/2007	\$15,016.97
--	-------------

I hereby certify that the amounts claimed herein are true and correct.

Signature

Date

Title

Regional Center
SAMPLE RC
1600 9th Street
Sacramento CA 95814

Telephone #
916-555-5555

- * Upon receipt of payment from the State Controller's Office, remit the above amount on line 5 to the RC at the above address.

Billing On Behalf Of Intermediate Care Facility:

ICF 15
ICF 15 OWNER
5555 JONES DRIVE
SOME CITY CA 95555 0015

ENCLOSURE A
Attachment C

REMITTANCE ADVICE		VENDOR-ID		PAGE 1		STATE OF CALIFORNIA DOF	
STD. 404C (REV. 4-95)		ICF0000015-00		THE ENCLOSED WARRANT IS IN PAYMENT OF THE INVOICES SHOWN BELOW			
DEPARTMENT NAME	ORG. CODE	INVOICE DATE	INVOICE NUMBER	INVOICE AMOUNT			
DEPARTMENT OF DEVELOPMENTAL SE	4310	03/21/11	301072007001				
DEPARTMENT ADDRESS	CLAIM SCHED. NO.						
P.O. BOX 944202	ICF0005	COASTAL/WESTSIDE RC #376					
SACRAMENTO CA 94244-2020		PERIOD 7/1/2007-9/30/2007					
VENDOR							
ICF 15		03/21/11 301072007001					
555 JONES DRIVE		13774.70					
SOME CITY CA 95555-0015		DAY/TRANSPORTATION COSTS					
PMT INQUIRIES: (916)454-1575							
FEDERAL TAX ID NO. OR SSAN	RP TYPE	TAX YR	TOTAL REPORTED TO IRS	TOTAL PAYMENT			
			.00	13774.70			

REMITTANCE ADVICE		VENDOR-ID		PAGE 1		STATE OF CALIFORNIA DOF	
STD. 404C (REV. 4-95)		ICF0000015-00		THE ENCLOSED WARRANT IS IN PAYMENT OF THE INVOICES SHOWN BELOW			
DEPARTMENT NAME	ORG. CODE	INVOICE DATE	INVOICE NUMBER	INVOICE AMOUNT			
DEPARTMENT OF DEVELOPMENTAL SE	4310	03/21/11	301072007001				
DEPARTMENT ADDRESS	CLAIM SCHED. NO.						
P.O. BOX 944202	ICF0006	COASTAL/WESTSIDE RC #376					
SACRAMENTO CA 94244-2020		PERIOD 7/1/2007-9/30/2007					
VENDOR							
ICF 15		03/21/11 301072007001					
555 JONES DRIVE		206.62					
SOME CITY CA 95555-0015		REG CNTR ADMIN FEES					
PMT INQUIRIES: (916)454-1575							
FEDERAL TAX ID NO. OR SSAN	RP TYPE	TAX YR	TOTAL REPORTED TO IRS	TOTAL PAYMENT			
				209.72			

REMITTANCE ADVICE		VENDOR-ID		PAGE 2		STATE OF CALIFORNIA DOF	
STD. 404C (REV. 4-95)		ICF0000015-00		THE ENCLOSED WARRANT IS IN PAYMENT OF THE INVOICES SHOWN BELOW			
DEPARTMENT NAME	ORG. CODE	INVOICE DATE	INVOICE NUMBER	INVOICE AMOUNT			
DEPARTMENT OF DEVELOPMENTAL SE	4310			ICF-DD ADMIN FEES			
DEPARTMENT ADDRESS	CLAIM SCHED. NO.						
P.O. BOX 944202	ICF0006	03/21/11 301072007001					
SACRAMENTO CA 94244-2020		825.93					
VENDOR		QUALITY ASSURANCE FEE					
ICF 15							
555 JONES DRIVE							
SOME CITY CA 95555-0015							
PMT INQUIRIES: (916)454-1575							
FEDERAL TAX ID NO. OR SSAN	RP TYPE	TAX YR	TOTAL REPORTED TO IRS	TOTAL PAYMENT			
			.00	1242.27			

ENCLOSURE B**ICF DD SPA ACKNOWLEDGEMENT AND AUTHORIZATION FORM**

Pursuant to Welfare and Institutions Code Sections 4646.55 and 14132.925, and the approved State Plan Amendment 07-004 to the State's Title XIX Plan, the undersigned ICF agrees to provide the day treatment and transportation services selected through the regional center individual program plan process (WIC 4646 and 4646.5), and authorizes the regional center to bill the Department of Developmental Services (DDS), on its behalf. The undersigned ICF understands that the regional center and DDS are responsible for determining the accuracy and appropriateness of such billing. Changes of ownership or changes of the licensed operator do not disqualify the undersigned ICF from participating in this supplemental program.

The undersigned ICF also acknowledges the requirement to pay the regional center the day treatment and transportation costs and associated regional center administrative fee, within 30 days of receipt of payment from DDS. Changes of ownership or changes of the licensed operator do not disqualify the undersigned ICF from participating in this supplemental program.

This agreement is effective as of the effective date of SPA 07-004.

ICF Provider Signature

Date

Legal Business Name and Address: _____

Email Address: _____

Telephone Contact Number: _____

For each of the ICF-DD, DD-H and DD-N facilities you operate, please provide the information listed below: You may attach additional pages to this document for submission to DDS.

Name of Facility: _____

Street Address: _____

City and Zip Code: _____

Phone Number: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003) (Revised for DDS ICF-DD Program 3/11/2011)

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.		
2	PAYEE'S LEGAL BUSINESS NAME (Type or Print)		
	SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)		E-MAIL ADDRESS
	FACILITY NAME		NPI/LOC#
	FACILITY ADDRESS		MAILING ADDRESS
	CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE
3	PAYEE ENTITY TYPE CHECK ONE BOX ONLY		ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):
	<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST		CORPORATION: <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS
	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: 		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
4	PAYEE RESIDENCY STATUS <input type="checkbox"/> California resident – Qualified to do business in California or maintains a permanent place of business in California. <input type="checkbox"/> California nonresident (see reverse side) – Payments to nonresidents for services may be subject to State income tax withholding. <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached.		
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.		
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)		TITLE
	SIGNATURE	DATE	TELEPHONE ()
6	Please return completed form to: Department of Developmental Services Accounting Office – Attn: Ann Gray P.O. Box 944202 (MS-3-7) Sacramento, CA 94244-2020 Telephone: (916) 654-2987 Fax: (916) 654-2898 E-mail: ann.gray@dds.ca.gov		

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD - INSTRUCTIONS

STD. 204 (Rev. 6-2003) (Revised for DDS ICF-DD Program 3/11/2011)

1	<p><u>Requirement to Complete Payee Data Record, STD. 204</u></p> <p>A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies.</p> <p>Payees who do not wish to complete the STD. 204 may elect to not do business with the State. If the payee does not complete the STD. 204 and the required payee data is not otherwise provided, payment may be reduced for federal backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.</p>
2	<p>Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. Enter facility name, address, and National Provider Identification # and Location #. The mailing address should be the address at which the payee chooses to receive correspondence and payments.</p>
3	<p>Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State provide their Taxpayer Identification Number (TIN). The TIN is required by the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a).</p>
4	<p><u>Are you a California resident or nonresident?</u></p> <p>A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California.</p> <p>A partnership is considered a resident partnership if it has a permanent place of business in California. An estate is a resident if the decedent was a California resident at time of death. A trust is a resident if at least one trustee is a California resident.</p> <p>For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.</p> <p>Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are \$1,500 or less for the calendar year.</p> <p>For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below. Withholding Services and Compliance Section: 1-888-792-4900 E-mail address: wscs.gen@ftb.ca.gov For hearing impaired with TDD, call: 1-800-822-6268 Website: www.ftb.ca.gov</p>
5	<p>Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.</p>
6	<p>This section must be completed by the State agency requesting the STD. 204.</p>
	<p><u>Privacy Statement</u></p> <p>Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.</p> <p>It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and State law imposes noncompliance penalties of up to \$20,000.</p> <p>You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the State agency(ies) with which you transact that business.</p> <p>All questions should be referred to the requesting State agency listed on the bottom front of this form.</p>

Intermediate Care Facilities
Payment for Transportation and Day Treatment Costs
Proposed Amendments

Section 1. Section 4646.55 is added to the Welfare and Institutions Code to read:

4646.55 (a) Notwithstanding any other provision of law or regulation to the contrary and to the extent federal financial participation is available, effective July 1, 2007, the California Department of Developmental Services is hereby authorized to make supplemental payment to Medi-Cal providers that are licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled for day treatment and transportation services provided pursuant to Sections 4646, 4646.5 and applicable regulations and 14132.92, to Medi-Cal beneficiaries residing in a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled. These payments shall be considered supplemental payments to the Medi-Cal providers and shall be comprised of the full costs of paying Regional Centers to arrange day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for the increased costs associated with the Quality Assurance fee.

(b) Notwithstanding any other provision of law and to the extent federal financial participation is available, and in furtherance of this section and 14132.925, the Department of Developmental Services shall amend the regional center contracts for the fiscal year 2007-08 to extend the contract liquidation period until June 30, 2011. The contract amendments and budget adjustments shall be exempt from the provisions of Article 1, (commencing with Section 4620) of Chapter 5 of Division 4.5 of the Welfare and Institutions Code.

Section 2. Section 14132.925 is added to the Welfare and Institutions Code to read:

(a) Notwithstanding any other provision of law or regulation to the contrary and to the extent federal financial participation is available, and in furtherance of Section 14105.06 and subdivisions (a) and (c) of Section 14132.92 effective July 1, 2007, a licensed intermediate care facility/developmentally disabled-habilitative, a licensed intermediate care facility/developmentally disabled-nursing or a licensed intermediate care facility/developmentally disabled shall be

ENCLOSURE D

responsible for providing day treatment and transportation services, consistent with 14105.06 and subdivision (a) of Section 14132.92, that are selected and authorized through the individual program plan process pursuant to Sections 4646, 4646.5 and applicable regulations for each beneficiary receiving such services who resides in that licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled. These services shall be arranged by the regional center pursuant to Sections 4646, 4646.5 and applicable regulations, and the licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled, shall reimburse the regional center for the full costs incurred in arranging for such services. The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall not substitute day treatment or transportation services for the day treatment and transportation services selected and authorized through the individual program plan process pursuant to Sections 4646, 4646.5 and applicable regulations.

(b) The State Department of Developmental Services shall be responsible for reimbursing a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled for the costs of reimbursing the Regional Center for the full costs of arranging the day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for the increased costs associated with the Quality Assurance fee. This payment shall be a supplement to the Medi-Cal payment from the Department of Health Care Services described in 14105.06 and 14132.92. A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled may authorize the Regional Center to invoice the State Department of Developmental Services on its behalf for arranging for the services described in subdivision (a). The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall reimburse the Regional Center the full cost of arranging for the day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instruction from the State Department of Developmental Services. If a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled fails to

ENCLOSURE D

reimburse the Regional Center within 30 days of receipt of payment from the Department of Developmental Services, for all or part of the costs associated with arranging for the day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

- (1) lump sum payment by the provider;
- (2) offset against current payments due to the provider from the State of California; or (3) a repayment agreement between the provider and the State of California.

(c) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall report the costs incurred pursuant to subdivision (a) according to instruction from the Department of Health Care Services. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the Department of Health Care Services may implement this subdivision by means of a provider bulletin or similar instruction.

(d) If services meeting the conditions of subdivision (a) have been provided to a MediCal beneficiary on or after July 1, 2007, and, notwithstanding Section 14115, a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled may authorize the Regional Center to invoice the State Department of Developmental Services on its behalf for arranging for the services described in subdivision (a). The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled shall reimburse the Regional Center the full cost of arranging for the day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instruction from the State Department of Developmental Services. If a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing or licensed intermediate care facility/developmentally disabled fails to reimburse the Regional Center within 30 days of receipt of payment from the Department of Developmental Services, for all or part of the costs associated with arranging for the day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

ENCLOSURE D

- (1) lump sum payment by the provider;
- (2) offset against current payments due to the provider from the State of California; or (3) a repayment agreement between the provider and the State of California.

(e) The department shall seek federal financial participation, including American Recovery and Reinvestment Act money, pursuant to a federally approved state plan amendment authorizing reimbursement for these services provided during that period. Upon approval of the amendment the payments made pursuant to this section shall be subject to the Quality Assurance fee provided for in Health and Safety Code Sections 1324 through 1324.14. If federal financial participation is not made available for that period, the services nonetheless shall be reimbursed from the General Fund by the Department of Developmental Services.

(f) The Department of Health Care Services shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this section. The Director of the Department of Health Care Services, with the concurrence of the Director of the Department of Developmental Services, may alter the methodology specified in this section, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If after seeking federal approval, federal approval is not obtained or federal financial participation is no longer available, this section and section 4646.55 shall not be implemented or shall become inoperative.

Section 3. Due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provided to a Medi-Cal beneficiary residing in a licensed intermediate care facility/developmentally disabled-habilitative, a licensed intermediate care facility/developmentally disabled-nursing or a licensed intermediate care facility/developmental disability, as specified in Section 4646.55 and 14132.925, funds appropriated in Item 4300-101-0001, Budget Act of 2007 (Chapters 171 and 172, Statutes of 2007), shall be available for liquidation until June 30, 2011.

RETROACTIVE CLAIMING PROCESS – ICF SUPPLEMENTAL SERVICES REPORTING DATABASE

“Excel ICF Data File”:

To expedite the retroactive billing and reimbursement process, the Department of Developmental Services (Department) has produced and will provide an “Excel ICF Data File” for each regional center. The Department has matched Department of Health Care Services (DHCS) ICF/DD, ICF/DD-H and ICF/DD-N paid ICF resident claims with the corresponding Department/regional center claim data for the consumer’s day and transportation services by **quarter**, starting with the first quarter of FY 2007/08.

Available attendance data in the Uniform Fiscal System was also used in the data match. This matching process produced one “Excel ICF Data File” for each regional center’s use in developing their claim for regional center day treatment and related transportation services purchased on behalf of ICF providers. The information in the file includes, but is not limited to:

Regional Center name; ICF provider name; ICF legal business address (facility address); ICF mailing address; ICF national provider number; consumer medical identification number; the to and from residential dates the ICF billed DHCS; whether the “Time Period” for billing was for a “Partial” or “Full” billing month; day treatment and/or transportation service code; service subcode; the journal entry number for the billing; status; invoice number; authorization number; the number of units of day treatment attendance and/or transportation billed; the unit claimed, ICF residence accommodation codes; the claim amount; a column for a revised unit amount; a column for a revised claim amount; and a comment section. (See SPA Legend).

In addition to the “Excel ICF Data File”, the Department will provide a Microsoft Access database application. This database application, based upon the total Day Treatment and Transportation costs determined by the regional center to be claimed for a specified time period, will automatically calculate appropriate administrative fees and Quality Assurance Fees, and will produce the three (3) required “ICF Supplemental Services Reports” described below:

1. **ICF Supplemental Services Detail Report** – a detailed report, a copy of which is provided by the regional center to the respective ICF, that includes the regional center’s total payment claim information for day treatment and transportation services to be invoiced for consumers that resided in each ICF for a specific time period;
2. **ICF Supplemental Services Summary Claim Report** – a summary report, a copy of which is provided by the regional center to the ICF, which informs the ICF of the amount of funds to be remitted to the regional center. This report includes: The regional center’s total day treatment and transportation service claim for a specific time period (e.g., July 1, 2007 to September 30, 2007), and the regional center’s

administrative fee (this subtotal is to be remitted to the respective regional center); The ICF's administrative fee; and the ICF's Quality Assurance Fee; and

3. **Regional Center ICF Claim Report** – Listing of all ICF claims as determined by the regional center. This report includes the sum of day treatment and transportation services costs, the regional center administrative fees, the ICF administrative fees, and the Quality Assurance Fee. The day treatment and transportation claim amount and regional center administrative fee shall be received by the regional center from the ICF providers. The day treatment and transportation claim amount shall be remitted to the Department by the regional center upon receipt from the ICF providers.

Claim Verification Process:

Prior to submitting its claim, it is imperative that the regional center, using the "ICF Excel Data File", review and verify the day treatment and transportation services data with the ICF residential billing data to ensure that the consumer identified was in residence at the facility and received said services.

- Particular attention should be given to the "**Time Period (T)**", (Column BV), of the Excel Data File. The **(T)** identifies consumers by either an "**F**", or by a "**P**".
- "**F**" - for "**Full Month**", represents consumers that resided at the same ICF for an entire month and received day treatment and transportation services.
- "**P**" - for "**Partial Month**", represents consumers that did not reside at the ICF for the full month and received day treatment and transportation services.
- The regional center must review the Excel Data File and make any corrections to the invoice lines, update the "**ICF Status**" ("**S**"), (Column BW), line(s) and enter revised claim units, (Column BX), and revised claim amount(s), (Column BY), where appropriate.

Please note the "**ICF Status**" ("**S**") (Column BW), directly to the right of the **(T)** column. For "**Partial Month**", ("**P**") consumers, their "**S**" is **blank** because it represents consumers that may have resided in more than one (1) ICF during the month. To submit a claim, the regional center may need to adjust this data to reflect the days the consumer received day treatment and transportation services at each ICF to ensure that the total claim is not overstated. This adjustment, if needed, should be entered under the columns labeled "revised unit amount (Column BX)" and "revised claim amount (Column BY)".

After regional center verification of "**Partial Month**" consumers, either "**A**" or "**D**" must be entered into the **blank** line under the ("**S**") column. No record should be left with their "**ICF Status**" line **blank**.

ENCLOSURE B

“**A**” must be entered on the “**S**” line if services are to be billed, and the units and dollars adjusted as appropriate for inclusion in invoices/reports;

“**D**” must be entered on the “**S**” line if services are not to be billed. “**D**” allows the information to remain in the file, but is not to be calculated for billing.

It is equally important to verify the data representing consumers that resided in the ICF for the “**Full Month**”, (“**F**”), for which the “**S**” line is already filled in as “**A**”. It is possible that the ICF is “no longer in business”* or the service was billed in error. If the ICF is out of business, or the service should not be billed, the “**S**” line must be changed from “**A**” to “**D**”. It is the responsibility of each regional center to ensure the accuracy of all data (day treatment and transportation claims) and their total claim.

***NOTE:** A change of ownership (CHOW) is not the same as “no longer in business”. The regional center may claim for day treatment and related transportation services that were provided to consumers residing at ICFs that have completed a CHOW. To do so, the Regional center must: 1) verify the current owner and billing information and update all ICF related fields in the Excel ICF Data File; 2) Obtain completed “ICF DD SPA Acknowledgement and Authorization Form” and Payee Data Record Form (Std. 204); 3) Send copies of forms to Department with “Regional Center ICF Claim Report; and 4) Indicate the change by stating “CHOW” in the comment section of Excel ICF Data File.

To further assist you in verifying the information, the files also contain demographic information about the ICF provider and the regional center consumer and DHCS accommodation codes that show if the consumer had a “Bed Hold” or “Leave of Absence” during that month. This means that the consumer was not at the ICF during that time period and might not have received day treatment or transportation services. If the consumer was hospitalized it’s possible no day treatment or transportation services were provided. However, if the consumer went on a family home visit or “Leave of Absence”, day treatment services may still have been provided. The family might have taken the consumer to the day treatment service. These exceptions will need to be researched by the regional center.

Below is a list of accommodation codes taken from the Long Term Care Provider Manual at www.medi-cal.ca.gov.

Description	Regular Services	Leave Days DD Patient
<i>ICF Developmental Disability Program</i>	41	43
<i>ICF/DD-H 4-6 Beds</i>	61	63
<i>ICF/DD-H 7-15 Beds</i>	65	68
<i>ICF/DD-N 4-6 Beds</i>	62	64
<i>ICF/DD-N 7-15 Beds</i>	66	69

Claim Verification Rules:

This retroactive reimbursement process is only for ICF/DD, ICF/DD-H and ICF/DD-N eligible **Medicaid** residents who **received** day treatment and related transportation services purchased by regional centers during prior fiscal-years.

- The “Excel ICF Data File” is to be imported into the Microsoft Access Database provided by the Department and must remain intact to perform correctly;
- Do not alter the original file by adding rows or columns;
- Only update fields in the file as specified in the instructions;
- You may copy the file if you wish manipulate, etc.

Day treatment services shall **not** be invoiced for ICF reimbursement where the ICF provider is no longer available to reimburse the regional center (out of business)¹, or where the ICF resident:

- Was not Medicaid eligible; or
- Did not receive day treatment services for any reason (vacation, doctor or dental appointments, sick for the day, on bed hold due to hospitalization, etc.)

Transportation services shall **not** be invoiced for the ICF reimbursement where the ICF provider is no longer available to reimburse the regional center (out of business), or where the resident:

- Was not Medicaid eligible;
- Did not use the vendored transportation service to receive day treatment; or
- Did not receive day treatment services for that day.

Transportation services may be invoiced for one-way only if there is a claim paid for one-way transportation. See example below:

Example: Day treatment and transportation services provided to a resident who transfers to another residential facility will be paid to the ICF provider where the resident resided at 12:00 am of the day that the resident transferred. For example, a resident transferred from ICF A to ICF B on July 20, 2007. The billing for ICF A should contain July services provided July 1, 2007 to July 20, 2007. The billing for ICF B should contain services provided on July 21, 2007 to July 31, 2007.

Completion of Claim Process:

After developing your claim for each quarter using information in the Excel ICF Data File, the regional center shall import the final version of the file into the Microsoft Access Database

¹ Change status line from ‘A’ to ‘D’ to maintain information but prevent inclusion into invoices/reports.

also provided by the Department, i.e., “**ICF Supplemental Services Access Database**” for use in producing the three (3) reports described under “**Excel ICF Data File**”.

Upon completion of each quarter, please return the corrected Excel Data File and the database, with **all three (3)** reports, to the Department via the iSeries Navigator as described below under “**Access/Return of Excel ICF Data File & Database**”.

A copy of the **ICF Supplemental Services Detail Report** and the **ICF Supplemental Services Summary Claim Report**, sent via the iSeries Navigator to the Department, shall be sent to the appropriate ICF providers for review and for their use in determining the amount of funds to be remitted to the regional center.

A hard copy of the original signed, **Regional Center ICF Claim Report** shall be sent to:

Ms. Linda Croslin, Chief
Department of Developmental Services
Health Facilities Program Section
1600 Ninth Street, Room 320 MS 3-11
Sacramento, CA. 95814

Access/Return of Excel ICF Data File & Database:

Due to the confidential nature of the Excel ICF Data File, the Regional Center System Operator shall access and return the Excel ICF Data Files as follows:

- Using the iSeries Navigator for your i5, expand File Systems, Integrated File System, and Root.
- Locate the folder named “ICFSPA”. This folder contains two subfolders: “**To RC**” and “**From RC**”.
- Excel ICF Data Files and the Microsoft Access Database application for producing ICF DD SPA reports will be placed in the “To RC” folder by quarter.
- DDS will notify the regional center by e-mail when a new file is available.
- The Regional Center System Operator will place returning Excel ICF Data Files, the Database with all three (3) required reports in the ‘From RC’ folder.
- Regional center will notify Linda Croslin at lcroslin@dds.ca.gov when a file is being returned to the ‘From RC’ folder.