THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☐ Imperial
☒ Riverside/San Bernardino
☐ Los Angeles
☐ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☒ Molina Medicare
☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care
☒ IPA/MSO
☒ Directs

Specialists
☒ Directs
☒ IPA

☒ **Hospitals**

Ancillary
☒ CBAS
☒ SNF/LTC
☒ DME
☒ Home Health
☒ Other

Subacute Care Facilities – Long Term Care Benefit Standardization And Transition Of Members To Managed Care APL 23-027

This is an advisory notification to Molina Healthcare of California (MHC) network providers to provide the requirements on the Subacute Care Facility Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

This notification is based on an All-Plan Letter (APL) 23-027, which can be found in full on the Department of Health Care Services (DHCS) website at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-027.pdf

WHAT YOU NEED TO KNOW:

BACKGROUND

Subacute Care Facility services include those provided to both adult and pediatric populations, that are provided by a licensed general acute care hospital with distinct part skilled nursing beds, or by a freestanding certified nursing facility. In each case, the facility must have the necessary contract with DHCS.

Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Adult subacute care is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility. Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

POLICY

I. Benefits Requirements

1. Subacute Care Services Benefits Requirements

   Effective January 1, 2024, MHC will authorize and cover Medically Necessary adult and pediatric subacute care services (provided in both freestanding and hospital-based facilities).

2. Other Benefits Requirements for Residents of Subacute Care Facilities

   If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid for by Medi-Cal Rx. If the drugs are provided by the Subacute Care Facility and billed on a medical or institutional claim, including physician administered drugs, MHC is responsible.

II. Network Readiness Requirements

As part of readiness, MHC will offer a contract to all Subacute Care Facilities within MHC's service areas that have a Subacute Care Contract with DHCS' SCU or are actively in the process of applying for a Medi-Cal Subacute Care Contract and are enrolled in Medi-Cal.

III. Leave of Absence or Bed Hold Requirements

MHC will provide continuity of care for Members who are transferred from a Subacute Care Facility to a general acute care hospital and then require a return to a Subacute Care Facility level of care due to Medical Necessity.

MHC will ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. MHC will allow the Member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold.

In a similar protection for Members who have been transferred from a Subacute Care Facility to a general acute care hospital, MHC will ensure that Members have the right to return to the Subacute Care Facility and to the same bed, if available or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization.

IV. Continuity of Care Requirements: Facility Placement

Effective January 1, 2024, through June 30, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, MHC will automatically provide 12 months of continuity of care for the Subacute Care Facility placement. Automatic continuity of care means that if the Member is currently residing in a Subacute Care Facility, they do not have to request continuity of care to continue to reside in that facility.

Following their initial 12-month automatic continuity of care period, Members may request an additional 12 months of continuity of care pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or After January 1, 2023, or any superseding APL.

A Member residing in a Subacute Care Facility who newly enrolls in MHC on or after July 1, 2024, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 23-022, or any superseding APL.

V. Continuity of Care Requirements: Medi-Cal Covered Services for Subacute Care Members with Existing Treatment Authorization Requests

1. Treatment Authorization Requests for Adult and Pediatric Subacute Care Services Under Per Diem Rate

   Effective January 1, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, MHC is responsible for covering treatment authorization requests (TARs) that are approved by DHCS and provided under the Subacute Care Facility per diem rate for a period of six months after enrollment in MHC, or for the duration of the TAR approval, whichever is shorter.

2. Treatment Authorization Requests for Other Services

   Effective January 1, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, MHC is responsible for covering all other services in TARs approved by DHCS (except for supplemental rehabilitation therapy services and ventilator weaning services for Members in pediatric

Subacute Care Facilities) provided in a Subacute Care Facility exclusive of the Subacute Care Facility per diem rate for a period of six months after enrollment in MHC, or for the duration of the TAR, whichever is shorter.

3. Treatment Authorization Requests for Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

   Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute patients. Reimbursement for these services is in addition to the per diem rate for pediatric subacute level of care services. An approved TAR is required for these services and is the responsibility of the nursing facility.

   Effective January 1, 2024, for pediatric Members residing in a Subacute Care Facility who are transitioning from Medi-Cal FFS to Medi-Cal managed care, MHC is responsible for covering supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS in a Subacute Care Facility for a period of three months after enrollment in MHC.

4. Expedited Prior Authorization Requests

   Effective January 1, 2024, MHC will expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to a Subacute Care Facility. MHC will make all authorization decisions in a timeframe appropriate for the nature of the Member's condition, and all authorization decisions will be made within 72 hours after MHC receives the relevant information needed to make an authorization decision.

VI. The Preadmission Screening and Resident Review

To prevent an individual from being erroneously admitted or retained in a Subacute Care Facility, federal law requires proper screening and evaluation before such placement. These Preadmission Screening and Resident Review (PASRR) requirements are applicable for all admissions at Medicaid-certified nursing facilities.

The PASRR process is required to ensure that individuals who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions.

VII. Facility Payment

For Contract periods from January 1, 2024, to December 31, 2025, inclusive, MHC will reimburse a Network Provider furnishing adult or pediatric subacute care services to a Member, and each Network Provider of adult or pediatric subacute care services must accept, the payment amount the Network Provider would be paid for those services in the Medi-Cal FFS delivery system, as defined by DHCS in the California's Medicaid State Plan and in guidance issued as authorized by W&I section 14184.102(d).

VIII. Payments for Medi-Cal Covered Services for Members Residing in a Subacute Care Facility

The state-directed payment requirements do not apply to any other services provided to a Member receiving adult or pediatric subacute care services such as, but not limited to, subacute services provided by an Out-of-Network Provider or non-subacute care services. Such non-qualifying services are not subject to the terms of this state directed payment and are payable by MHC in accordance with the terms negotiated between MHC and the Provider.

IX. Payment Processes Including Timely Payment of Claims

MHC will provide a process for Network Providers to submit electronic claims and to receive payments electronically if a Network Provider requests electronic processing, which must

include, but not be limited to, processing automatic crossover payments for Members who are dually eligible for Medicare and Medi-Cal. MHC will ensure that the Subacute Care Facility and its staff have appropriate training on benefits coordination, including balanced billing prohibitions.

X. Population Health Management Requirements

In addition to benefit standardization, effective January 1, 2023, MHC implemented a PHM Program that ensures all Members, including those using adult or pediatric subacute care services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), transitional care services (TCS), care management programs, and Community Supports, as appropriate.

BPHM applies an approach to care that ensures needed programs and services, including primary care, are made available to each Member at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, MHC Members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

WHAT IF YOU NEED ASSISTANCE?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below:

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