PROVIDER*Update*

health net

Request Authorization for Recuperative Care (Medical Respite Care)

Eligibility tips and recommended authorization process

Prior authorization is required for recuperative care (medical respite care).

Recuperative care is short-term, post-hospital, residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions), and whose condition would be exacerbated by an unstable living environment.

This service is covered up to 30 days, with extensions in 30-day increments based on medical necessity. There is a 90-day limit per authorization.

Follow these steps for faster review

Due to the information needed to find out if someone qualifies, we recommend using the below referral process to expedite authorization review:

1   The hospital confirms whether the member is currently an eligible Health Net* member.

2   The hospital interdisciplinary team (including the review nurse) determines if the member qualifies for recuperative care, based on the Community Supports (CS) recuperative care authorization guide, and advises on the best recuperative care provider for the member, based on capacity and member needs.

3   The hospital submits the authorization request for recuperative care services for the member to the Plan, along with the concurrent review updates. The clinical team will review and issue authorization if criteria are met for the member to receive services post-discharge.

4   The Plan notifies the hospital and recuperative care provider of the authorization status. After authorization approval is received, the hospital can send the member to a recuperative care provider.

Go to the online COVID-19 alerts page for info about COVID-19 vaccines!
At **provider.healthnet.com** > *COVID-19 Updates > Health Net Alerts*, you will find information about COVID-19 vaccines. This includes COVID-19 vaccine coverage details, how to enroll to administer the COVID-19 vaccine, and COVID-19 vaccine reporting and coding requirements. Also, access key tips you can use to help talk with and answer questions from your patients about the COVID-19 vaccine, especially those who are hesitant to receive it.

THIS UPDATE APPLIES TO CALIFORNIA PROVIDERS:
- Physicians
- Participating Physician Groups
- Hospitals
○ Ancillary Providers
- Community Supports (CS) Providers
- Enhanced Care Management (ECM) Providers

LINES OF BUSINESS:
○ IFP
  ○ Ambetter HMO   ○ Ambetter PPO
  ○ Ambetter EPO   ○ Full Network PPO
  ○ Ambetter HSP
○ Employer Group
  ○ HMO/POS/HSP
  ○ EPO
  ○ PPO
○ Medicare Advantage (HMO/PPO) (Wellcare By Health Net)
○ Cal MediConnect (Los Angeles/San Diego)
- Medi-Cal
  - Kern   - San Bernardino
  - Los Angeles   - San Diego
    ○ Molina   - San Joaquin
  - Riverside   - Stanislaus
  - Sacramento   - Tulare

PROVIDER SERVICES
800-675-6110

PROVIDER PORTAL
provider.healthnetcalifornia.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com

5   The recuperative care provider will provide service to the member and bill using the authorization number provided.

Member eligibility

Members must meet the following criteria to qualify for the recuperative care services:

Eligible persons	Restrictions
• Members who are at risk of hospitalization or who are post-hospitalization, and • Individuals who live alone with no formal supports; or • Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.	• Member is taking part in a duplicative state-funded program. • Should not replace or duplicate the services provided to members using the enhanced care management (ECM) program. • Not more than 90 days in continuous duration. • Does not include funding for building modification or building rehabilitation.

Program overview

The program and services include:

Program	Services
• For members who are homeless or with unstable living situations, and who are too ill or frail to recover from an illness/injury (physical or behavioral health) in their usual living environment, but who are not ill enough to be in a hospital. • Used to achieve or maintain medical stability and prevent hospital admission and/or readmission, which may require behavioral health interventions.	• Interim housing with a bed and meals; monitoring of the member's ongoing medical or behavioral health condition. May also include (if needed): - Limited or short-term assistance with instrumental activities of daily living (IADLs) and/or ADLs. - Coordination of transportation to post-discharge appointments. - Connection to any other ongoing services, including mental health and substance use disorder services. - Support in accessing benefits and housing. - Stability with case management relationships and programs. • Can be used with other housing CS. When possible, other housing CS should be provided to members on-site in the recuperative care facility.[1]

Total Lifetime Maximum: N/A.

Code: T2033 U6 Residential care, not otherwise specified (NOS), waiver.

Unit of Service: Per diem.

State services to be avoided: Examples include but are not limited to inpatient and outpatient hospital services, skilled nursing facility services and emergency department services.

Allowable Providers: Providers must have experience and expertise with providing these unique services.[2]

Background

Medical respite care is acute and post-acute medical care for people experiencing homelessness who are not ill enough to remain in the hospital but are too ill to recover on the streets or in regular shelter settings. Medical respite is short-

term residential and person-centered care that allows people experiencing homelessness to rest in a safe environment while accessing medical care and other supportive services.

While at the medical respite setting, it's best practice for people experiencing homelessness to receive:

- Support for medication management and adherence.
- Resolution of acute ongoing medical needs or diagnostic work ups.
- Bridging to primary care providing urgent care services.
- Linkages to psychosocial benefits, including mental health and substance use treatment.

People experiencing homelessness will receive the following array of services in a medical respite setting:

- Temporary congregate housing.
- Group meals, three times a day, including medically tailored meals as necessary.
- Bathrooms, showers and washing machines.
- Assistance with ADLs.
- Nursing care and hygiene support.
- Care management and care coordination for ongoing psychosocial needs.
- Medication management.
- Transportation and escorts to key appointments.
- Discharge coordination.

Medical respite programs also do the following:

- Decompress hospital emergency departments and improve patient flow by providing an appropriate and safe discharge destination for patients who no longer need acute hospital care but do not have a safe and stable place to recuperate.
- Provide medical and psychosocial services in a residential environment to homeless people with chronic medical needs that cannot be addressed in the current emergency shelter system.
- Decrease 911 calls and emergency medical technician utilization originating from shelters unable to address the problems of homeless people with chronic medical needs.
- Create safe non-emergency transfer and discharge options from the shelter system for homeless people with chronic medical needs.

Additional information

Providers are encouraged to access the provider portal online at provider.healthnetcalifornia.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Medi-Cal Provider Services Center within 60 days at 800-675-6110.

[1] Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), CS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. CS are optional for both the managed care plan and the member and must be approved by the Department of Health Care Services.

[2] Examples of types of providers: Interim housing facilities with additional on-site support; shelter beds with additional on-site support; converted homes with additional on-site support; county directly operated or contracted recuperative care facilities.