Policy:	GG.1130
Title:	**Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 05/15/2024*
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Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope of coverage, eligibility determination, authorization, availability, and care coordination processes for Members enrolled in the Community-Based Adult Services (CBAS) Program.

II. POLICY

A. CalOptima Health may elect to delegate the administration of CBAS to its contracted Health Networks. A Health Network delegated to provide CBAS services must comply with the provisions of this Policy.

B. CalOptima Health is responsible for determining CBAS eligibility and medical necessity criteria. CalOptima Health may receive an inquiry for CBAS from a CBAS center, a Member, Member's Authorized Representative, a Member's Primary Care Physician (PCP) or Specialist physician, a Member's Case Manager, or Personal Care Coordinator (PCC). CalOptima Health may also initiate an evaluation for CBAS based on the results of the Member's initial Risk Stratification or Health Risk Assessment (HRA) results.

1. For Members assigned to CalOptima Health and Health Networks, CalOptima Health Long Term Services and Supports (LTSS) Staff shall process all initial CBAS benefit inquiries and CBAS authorization requests.

C. To be eligible for CBAS, Members must meet eligibility and medical necessity criteria as follows:

1. Enrolled in CalOptima Health in the Medi-Cal or OneCare program; and

2. Be at least eighteen (18) years of age or older, or a Seniors and Persons with Disabilities (SPD) Member.

D. A Member must meet the CBAS medical necessity criteria for any one (1) or more of the following categories:

1. Meet Nursing Facility-A (NF-A) level of care criteria or above, and the eligibility and medical necessity criteria contained in the Welfare and Institutions Code, sections 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e).

2. Have an organic, acquired, or traumatic brain injury, and/or Chronic Mental Disorder, and demonstrate a need for assistance or supervision with at least:

    a. Two (2) of the following activities of daily living/instrumental activities of daily living (ADLs/IADLs): bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; or

    b. One (1) ADL/IADL listed above, and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

3. Have moderate to severe cognitive disorder, such as Alzheimer's Disease, or other dementia characterized by the following stages:

    a. Stage 5: Moderately severe cognitive decline: major gaps in memory and deficits in cognitive function emerge with some assistance with day-to-day activities becoming essential;

    b. Stage 6: Severe cognitive decline: memory difficulties that continue to worsen, significant personality changes emerging, and requiring extensive assistance with daily activities;

    c. Stage 7: Very severe cognitive decline: This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement.

4. Have mild cognitive impairment, including moderate Alzheimer's disease or other dementia, characterized by the descriptors of Stage 4 Alzheimer's Disease (defined as mild or early-stage Alzheimer's) as follows:

    a. Manifest one or more of the following conditions:

        i. Decreased knowledge of recent events;

        ii. Impaired ability to perform challenging mental arithmetic;

        iii. Decreased capacity to perform complex tasks;

        iv. Reduced memory of personal history; and

        v. The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations.

    b. Member also requires assistance or supervision with two (2) of the following ADLs/IADLs:

        i. Bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

5. Have developmental disabilities that meet Regional Center of Orange County (RCOC) criteria and eligibility.

E. CBAS Eligibility Determination Tool (CEDT): CalOptima Health shall utilize the Department of Health Care Services (DHCS)-approved CEDT to determine if a Member meets CBAS eligibility and medical necessity criteria requirements. The CalOptima Health LTSS Program Manager or designee shall administer appropriate training on using the DHCS-approved CEDT assessment tool and CBAS medical necessity criteria.

1. CalOptima Health LTSS registered nurse, contracted registered nurse, with level of care determination experience, shall perform a Face-to-Face (F2F) assessment of the Member within thirty (30) calendar days of receipt of the initial eligibility inquiry (During a public health emergency, such as the COVID-19 Pandemic, the F2F evaluation may be completed via phone):

    a. The CBAS CEDT F2F assessment shall include an evaluation of a Member's health status including medical, psychosocial, cognitive, functional, therapeutic, social, or other needs.

2. CalOptima Health shall not require an initial F2F review when adequate documentation is available to make a determination that a Member is eligible to receive CBAS.

3. CalOptima Health LTSS Clinical Staff shall make CBAS eligibility and medical necessity determinations based on available clinical documentation. The documents CalOptima Health LTSS Clinical Staff may utilize include, but are not limited to:

    a. History and physical (H&P);

    b. Laboratory results;

    c. Diagnostic reports;

    d. Medication profiles;

    e. Facility discharge summary; and

    f. PCP and/or Specialist's progress notes.

4. CalOptima Health LTSS Clinical Staff shall approve CBAS services based on CBAS eligibility and medical necessity criteria.

5. A CalOptima Health Medical Director shall be the only staff that may modify or deny the request for CBAS.

F. If a CBAS center has not been identified, as part of the initial assessment, CalOptima Health shall refer Members to a CBAS center based on Member choice, cultural and linguistic needs, clinical condition, and/or geographic proximity to the Member's residence. CalOptima Health shall consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS provider.

G. CalOptima Health shall ensure the Member has the right to receive services at the CBAS center of their choice.

H. CalOptima Health shall ensure CBAS access and availability standards are met in accordance with GG.1600: Access and Availability Standards.

I. CalOptima Health shall ensure that telehealth delivery of CBAS will meet HIPPA requirements and the methodology is accepted by the CalOptima Health Chief Compliance Officer and delivered in accordance with CalOptima Health GG.1665: Telehealth and Other Technology-Enabled Services and MA.2100: Telehealth and Other Technology-Enabled Services.

J. Where there is insufficient or non-existent CBAS capacity in CalOptima Health's covered geographic services area, CalOptima Health shall arrange for the delivery of appropriate plan-covered benefits and communicate with community resources to assist Members, who have similar clinical conditions as CBAS recipients to remain in the community.

K. CalOptima Health shall cover CBAS as a bundled service through a certified CBAS provider or arrange for the provision of unbundled CBAS based on the assessed needs of the Member if a certified CBAS provider is not available or not contracted, or there is insufficient CBAS provider capacity in the area.

L. Unbundled Services

1. If CalOptima Health has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima Health may authorize unbundled services and facilitate utilization through care coordination. Unbundled services authorized by Contractor are limited to:

a. Core Services:

i. Professional nursing services;

ii. Personal care services;

iii. Social Services;

iv. Therapeutic services: Physical and Occupational maintenance therapy; and

v. Nutrition/Registered Dietician/Meal

b. Additional Services:

i. Physical therapy;

ii. Occupational therapy;

iii. Speech and language pathology services;

iv. Mental health services;

v. Covered non-specialty mental health services and/or substance use disorder services; and

vi. Non-Emergency Medical Transportation (NEMT) only between the Member's home and the CBAS unbundled service provider.

M. If a Member does not meet CBAS eligibility and medical necessity criteria, CalOptima Health shall deny the request and notify the CBAS center and/or Member, as appropriate, in accordance with the terms and conditions outlined herein.

N. CalOptima Health shall notify a Member of the denial decision, in writing, by using the denial Notice of Action (NOA) or Notice of Determination (NOD) that addresses Member's right to file an Appeal and/or Grievance under State and Federal Law.

O. A Member or Member's Authorized Representative may file a Grievance with CalOptima Health in written or oral complaint, in accordance with CalOptima Health Policies HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.

P. CalOptima Health may dismiss an authorization request for a OneCare Member, either entirely or as to the stated issue, in accordance with the terms and conditions outlined herein.

Q. CalOptima Health shall notify a Member of the dismissal, in writing, by using a Notice of Dismissal that addresses Member's right to file an Appeal and/or Grievance under State and Federal Law.

R. A CBAS Center shall convene a Multidisciplinary Team (MDT) comprised of the following health care provider representatives: CBAS Center Medical Director and staff, the Member and/or the Member's Authorized Representative(s). The CBAS center may invite CalOptima Health LTSS Clinical or Social Work staff, CalOptima Health or Health Network Case Managers, and/or PCCs to participate in their MDT, as appropriate.

    1. The CBAS MDT and the Member's Individual Plan of Care (IPC) will determine the need for additional CBAS services. These additional CBAS services may include physical, occupational or speech therapies, behavioral health services, registered dietician services, and transportation services to and from the CBAS center and Member's residence.

S. CBAS Centers must make Emergency Remote Services (ERS) available to their Members under unique circumstances when all CBAS ERS criteria are met. These unique circumstances include public emergencies such as state and local disasters, and personal emergencies such as illness, injury, crises, or care transitions.

    1. The determination of meeting these unique circumstances will be made by the CBAS provider in consultation with CalOptima Health and the Member's need must be appropriately documented.

    2. All emergencies resulting in ERS must be assessed initially by the CBAS center RN and social worker, with care plans modified as needed by the full CBAS multidisciplinary team.

    3. CalOptima Health and the CBAS provider will coordinate to ensure that service and support needs are met, and as indicated, the duration for provision of ERS.

    4. A Member's emergency alone does not warrant provision of ERS. The Member must experience a public or personal emergency and need the services and supports CBAS provides under ERS.

    5. Members may choose to cease receipt of ERS at any time.

T. CalOptima Health shall cover ERS as part of the CBAS benefit when CBAS participants meet the criteria established in the ERS policies and CBAS providers meet provider participation standards. CBAS ERS policies are identified in CDA CBAS Bureau All Center Letter (ACL) 22-04: Launch of New CBAS Emergency Remote Services (ERS).

U. For any in-home services provided to CBAS beneficiaries under the CBAS ERS, CBAS providers are required to utilize the Electronic Visit Verification System (EVV). CalOptima Health shall verify and monitor providers and caregivers to ensure they are using an EVV system for logging their EVV visit data consistently and completely.

1. CalOptima Health shall implement EVV requirements for Home Health Care Services (HHCS) by January 1, 2023.

2. EVV will be required for all Medi-Cal Personal Care Services (PCS) and HHCS that are delivered during in-home visits by a provider. This includes visits that begin in the community and end in the home (or vice versa).

V. ERS services conclude when:

1. Emergency conditions cease, and participant can receive necessary services at the center; or

2. When the participant requires discharge from the center.

3. The CBAS center is responsible to notify CalOptima Health of any changes to the Member's ERS dates.

W. CalOptima Health will work collaboratively with its contracted CBAS providers as Temporary Alternative Services (TAS) has ended to ensure each Member's needs continue to be met, whether through in-person services provided at the CBAS center or through ERS, and that the Member's needs are documented appropriately.

1. CBAS providers will be responsible for updating CalOptima of any changes in service provision, either by submitting a CBAS Member Discharge Plan and Reason form or an updated IPC with an authorization request form.

2. CalOptima Health will document changes and coordinate care as appropriate per this policy or CalOptima Health Policy GG.1829: Community-Based Adult Services (CBAS) Discharge Notification Process.

X. CalOptima Health shall ensure continuity of care when a Member changes health plans and/or transfers from one CBAS center to another pursuant to CalOptima Health Policies GG.1304: Continuity of Care During Health Network or Provider Termination, MA.6021a: Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners, and GG.1829: Community Based Adult Services (CBAS) Discharge Notification Process.

1. CalOptima Health shall provide continuity of care to Members through continued access to a CBAS provider with whom there is an existing relationship for up to twelve (12) months after Member enrollment. This requirement shall include Out-of-Network Providers if there are no quality-of-care issues and the Provider will accept either CalOptima Health or Medi-Cal Fee for Service (FFS rates, whichever is higher, in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

Y. CalOptima Health will ensure CBAS providers receive advanced written notification and training prior to any substantive changes in CalOptima Health's policy and procedures related to CBAS.

Z. CalOptima Health will collaborate with CBAS providers to ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

III. PROCEDURE

A. A request for evaluation of eligibility for CBAS services may be submitted directly to the CalOptima Health LTSS Department from any of the sources identified in this Policy.

B. To initiate the CBAS assessment process, any request to CalOptima Health LTSS must include the following documents:

1. A completed CBAS Benefit Inquiry Form;

2. Member clinical information, such as:

a. Physician's order;

b. Recent history and physical (H&P) (dated no more than thirty (30) calendar days prior to submission of benefit inquiry);

i. The Member's Primary Care Physician (PCP) shall complete the H&P.

ii. The CBAS center physician may conduct the initial H&P exam if the Member does not have an assigned PCP during the evaluation process or the PCP is unavailable.

c. Prescription medications, if any; and/or

d. Hospital or skilled nursing discharge instructions or summary, as applicable.

C. Benefit Inquiry Process

1. CalOptima Health's LTSS Staff shall conduct a pre-screening eligibility assessment for CBAS benefit inquiry requests. The pre-screening eligibility assessment may include the following questions:

a. Is the individual eligible with CalOptima Health;

b. Is the Member's age at least eighteen (18) years or older;

c. Is the Member an SPD Member, including those who receive Medicare with another health plan or Medicare FFS; and

d. Does the Member have a preferred spoken and/or written language.

2. CalOptima Health LTSS clinical and support staff are responsible for processing CBAS benefit inquiries and authorization requests for Members as detailed in this Policy and as follows:

a. Routine Initial Request:

i. Upon receipt of a CBAS benefit inquiry request, CalOptima Health LTSS Staff shall:

a) Perform the pre-screening eligibility and send an "Acknowledgment Letter" to the Member and Requestor;

b) CalOptima Health LTSS Social Worker shall call the Member, complete the psycho-social assessment, and schedule the F2F assessment within fourteen (14) calendar days from receipt of benefit inquiry:

1) A social worker shall perform a social services assessment that includes the Member's general information, cultural and linguistic needs, risk factors, current support systems, verify contact information, identify primary care physician and specialist information. The social worker will offer the Member a list of CBAS centers from which to make a selection and will encourage participation in the Interdisciplinary Care Team (ICT) as appropriate.

2) If Member chooses to withdraw his/her request to attend CBAS the process will stop; an assessment will not be completed and the F2F evaluation will not be scheduled. CalOptima Health CBAS social worker will close the referral and send a Notice of Closure letter to the Member and Requestor.

3) If a referral is received on behalf of a Member and the Member is unaware of what CBAS is, the CalOptima Health CBAS social worker will educate the Member about CBAS services and provide up to three referrals to CBAS centers that meet the Member's geographical, language and service needs. If the Member is not ready to decide, he/she can choose to wait and tour the centers first before deciding, in which case the referral will be closed, and a Notice of Closure letter will be sent to the Member and Requestor. The Member will be advised to apply for CBAS directly through his/her CBAS center of choice when ready.

c) CalOptima Health will send F2F Appointment Confirmation Letter to the Member and Requestor;

d) If unable to reach Member on first attempt, CalOptima Health will make two (2) additional attempts via telephone to schedule F2F assessment between five (5) and eight (8) business days from receipt of the request;

e) Make final attempt in writing giving the Member until the 14th calendar day from date of inquiry to schedule F2F assessment.

ii. If F2F assessment is not scheduled within fourteen (14) calendar days from inquiry, CalOptima Health will send a follow-up letter to the Member and Requestor notifying in writing that if services are still needed a new inquiry must be submitted to begin the process again.

b. Expedited Initial Requests:

i. Expedited authorization requests shall be utilized when the Member is in a hospital or nursing facility and the Member's discharge plan includes CBAS, or when the Member faces imminent and serious threat to his/her health.

ii. Upon receipt of expedited CBAS benefit inquiry request, CalOptima Health LTSS Staff or contracted providers shall not be required to complete a F2F assessment when adequate documentation is available to make a determination that a Member is eligible to receive CBAS.

iii. An expedited authorization shall occur within seventy-two (72) hours from receipt of the initial inquiry.

D. CBAS CEDT F2F Assessment Process

1. A CalOptima Health or contracted registered nurse with level of care determination experience shall perform a CBAS CEDT F2F assessment for Members requesting CBAS for the first time, as needed, at the agreed upon location, date, and time, pursuant to guidance from the Department of Health Care Services (DHCS). CalOptima Health LTSS Clinical Staff or contracted registered nurse shall:

   a. Routine Requests

      i. Complete the CBAS CEDT F2F assessment within thirty (30) calendar days from receipt of initial inquiry.

      ii. Send the completed CBAS CEDT F2F assessment to CalOptima Health LTSS Department within three (3) business days of completion (not to exceed the 25th day from the date of the CBAS request inquiry) for review and determination.

   b. Expedited Requests

      i. LTSS Clinical Staff shall review available documentation to determine Member eligibility for CBAS services or complete the CBAS CEDT F2F assessment, when appropriate, within seventy-two (72) hours from receipt of the initial inquiry; and

      ii. Send the completed CBAS CEDT F2F assessment to the CalOptima Health LTSS Department upon completion, ensuring review and determination does not exceed seventy-two (72) hours from receipt of the initial inquiry.

E. MDT Assessment Process

1. CalOptima Health LTSS Clinical Staff or Medical Director shall approve eligibility for the CBAS Center 3-Day MDT evaluation based on the outcome of the F2F assessment and CEDT.

   a. If approved, CalOptima Health shall notify the CBAS center and Member and/or Member's Authorized Representative as follows:

      i. Initial notification to CBAS center within twenty-four (24) hours and written notification sent within two (2) working days of making the decision;

      ii. Written notification sent to the Member and/or Authorized Representative within two (2) working days of making the decision, not to exceed three (3) working days from the receipt of the request for services. If Member's primary language is other than English and it's one of CalOptima Health's threshold languages, the written notification shall be sent in the Member's threshold language. If Member's primary language is not one of CalOptima Health's threshold languages, the written notification shall be sent in English.

2. CalOptima Health's Medical Director may deny eligibility for the CBAS Center 3-Day MDT evaluation based on the outcome of the F2F assessment and CEDT.

a. A denial of CBAS medical eligibility shall be based on the outcome of the CEDT F2F assessment and will result in an NOA or NOD from CalOptima Health with an explanation of Member's Appeal rights and Grievance process.

i. Notify CBAS and Member and/or Member's Authorized Representative in accordance with Section III.E.1.ii of this Policy.

3. Based on the results of the F2F assessment, CalOptima Health LTSS Clinical Staff may refer Members not eligible for CBAS to Case Management for additional care coordination, Complex Case Management, Disease Management, Health Education or other community-based resources or services such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), or CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE).

4. Upon receipt of CalOptima Health's authorization for a 3-Day comprehensive MDT evaluation, a CBAS center shall:

a. Complete the in-person 3-Day MDT evaluation within the authorized thirty (30) calendar days.

i. If the CBAS center is unable to perform the 3-Day MDT evaluation within the allowed time for any reason, the CBAS center may submit a request for extension to CalOptima Health LTSS Department.

ii. The extension may be authorized for an additional thirty (30) calendar days;

b. Document the Member's IPC with level of service (LOS).

c. Complete a CBAS Authorization Request Form (ARF) for CBAS services.

d. Send the documentation to the CalOptima Health LTSS Staff and retain the original documents in the Member's CBAS health record. Documentation shall include recent H&P (dated no more than thirty (30) calendar days prior to submission of benefit inquiry) if not previously submitted with the benefit inquiry.

e. Make all reasonable efforts to assist the Member in establishing a relationship with the CBAS center by being sensitive to Member's cultural and linguistic preferences in accommodating Member's needs.

F. Individual Plan of Care (IPC)

1. A Member's IPC shall substantiate the medical needs for CBAS services. The IPC shall include, at a minimum, the following elements:

a. Medical diagnoses;

b. Prescribed medications;

c. Scheduled days at the CBAS center;

d. The types of services and frequency of core and additional services. Each CBAS participant will receive all of the core services on each day of attendance at the center and may receive additional services as specified in Member's IPC; and

e. Member's objectives, therapeutic goals, and duration of service(s);

2. A Member's IPC must be current based on assessment conducted no more than thirty (30) calendar days prior to the start of the IPC. The CBAS center staff, the Member, and MDT team shall review and update IPC at least every six (6) months and address Member's progress, goals, and objectives.

3. A current copy of the IPC must always be maintained in the Member's CBAS health record.

G. CBAS Services Authorization Process:

1. A CBAS center must submit the following documents via facsimile to the CalOptima Health LTSS department:

a. The completed CalOptima Health CBAS ARF to include the following information:

i. A start and an end date;

ii. Total number of days requested per month in a six (6) month period;

iii. The Member's IPC with supporting documentation for level of service; and

iv. Any additional assessments or supporting documentation as requested by LTSS Department.

2. When determining the appropriate number of days per calendar month to authorize CBAS services, CalOptima Health LTSS Clinical Staff shall consider the following five (5) factors:

a. Overall health condition of the Member, relative to the participant's ability and willingness to attend the number of days requested and as specified in the ARF and IPC;

b. The type of and frequency of services specified in the IPC;

c. The extent to which other services currently being received by the Member meet the Member's needs, as specified on the ARF and IPC;

d. The number of days requested on the ARF; and

e. The number of days as requested by the Member's PCP, Personal Health Care Provider, or CBAS center's physician.

f. CalOptima Health shall ensure that CBAS IPCs are consistent with the Member's overall care plan and goals.

3. CalOptima Health shall approve, modify, or deny the authorization request within five (5) business days of receipt of the authorization request, in accordance with this Policy.

4. If the result of the review substantiates that eligibility and medical necessity criteria have been met, the LTSS clinical staff will approve CBAS Services for six (6) to twelve (12) months at a time, in accordance with this Policy.

5. If the results of the review indicate that the Member does not meet the CBAS eligibility and medical necessity criteria, or that the number of or type of services requested are not substantiated, CalOptima Health shall not deny, defer, or reduce a requested level of CBAS for a Member without a F2F reviewed performed by a Registered Nurse with level of care determination experience and utilizing the assessment tool approved by DHCS. If the review does not substantiate CBAS eligibility and medical necessity criteria, LTSS clinical staff shall forward the request to CalOptima Health Medical Director for review and a decision, in accordance with this Policy.

6. CalOptima Health shall notify the CBAS center and the Member and/or Authorized Representative as follows:

    a. Initial notification to the CBAS center within twenty-four (24) hours and send written notification within two (2) working days of making the decision;

    b. Send written notification to the Member and/or Member's Authorized Representative within two (2) working days of making the decision, not to exceed three (3) working days from the receipt of the request for services. If Member's primary language is other than English and it's one of CalOptima Health's threshold languages, the written notification shall be sent in the Member's threshold language. If Member's primary language is not one of CalOptima Health's threshold languages, the written notification shall be sent in English.

H. CalOptima Health may dismiss an authorization request for a OneCare Member, either entirely or as to any stated issue, under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an authorization under Title 42, Federal Code of Regulations, § 422.566(c).

2. CalOptima Health determines the party failed to make out a valid request for an authorization.

3. A Member or the Member's Authorized Representative files a request for an authorization but the Member dies while the request is pending, and both of the following apply:

    a. The Member's surviving spouse or estate has no remaining financial interest in the case; and

    b. No other individual or entity with a financial interest in the case wishes to pursue the organization determination.

4. A party filing the authorization request submits a timely request for withdrawal of their request for an organization determination.

I. CalOptima Health shall mail or otherwise transmit a written notice of the dismissal of the authorization request to the parties. The notice must state all of the following:

1. The reason for the dismissal;

2. The right to request that CalOptima Health vacate the dismissal action; and

3. The right to request reconsideration of the dismissal.

J. Emergency Remote Services (ERS)

1. To initiate ERS, the CBAS center must complete all necessary assessments/evaluations and fill out the CBAS Emergency Remote Services Initiation Form (CEIF) (CDA 4000).

2. The CBAS center must send a copy of the completed CEIF to CalOptima Health:

    a. Within three (3) working days after the start of ERS;

    b. At least one (1) week prior to continuation of ERS for any Member whose emergency indicates a need for extending ERS beyond three (3) consecutive months; and

    c. For Members whose ERS timeframe crosses over an authorization period, CBAS providers are to attach the CEIF to the participants renewing authorization request.

3. If there is a need for ERS to extend beyond three (3) consecutive months, CalOptima Health will require the CBAS provider to complete an assessment and submit an updated IPC with request for authorization to determine the need for ongoing ERS Services.

4. CalOptima Health LTSS Staff will review all requests for ERS and coordinate with the CBAS provider to ensure that service and support needs are met during the duration of time CBAS services are provided via ERS.

    a. Requests for ERS that are fourteen (14) days or less will be processed by CalOptima Health as a presumptive approval if the CEIF and necessary documents are submitted to CalOptima Health.

    b. Any ERS requests greater than fourteen (14) days will be reviewed by a CalOptima Health Clinical Nurse Case Manager to determine ERS eligibility.

        i. If a Nurse Case Manager does not feel ERS is appropriate for the Member, they will consult a CalOptima Health Medical Director and issue a denial letter if services are not approved.

5. If the Member does not meet ERS eligibility and does not wish to attend the center in-person:

    a. The CBAS provider will notify CalOptima Health by submitting a CBAS Member Discharge Plan and Reason From and include whether the Member has any unmet needs under the discharge plan section.

    b. CalOptima Health will provide the Member with a packet of alternative resources provided by CalOptima Health, including PACE, MSSP, CalAIM, CalFresh, and Meal Delivery Programs.

K. CBAS providers are required to use an EVV system when CBAS services are delivered during in-home visits and must capture and transmit the following six mandatory data components: verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

1. CalOptima Health shall monitor CBAS providers to ensure compliance with EVV requirements in accordance with the established guidelines below:

a. Monitor CBAS providers for compliance with the EVV requirements and California Electronic Visit Verification (CalEVV) Information Notice(s), and alert DHCS to any compliance issues;

b. Supply CBAS providers with technical assistance and training on EVV compliance, in accordance with EE.1103: Provider Network Training;

c. Require out-of-compliance CBAS providers to comply with an approved corrective action plan; and

d. Deny payment if the CBAS provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply.

L. Planned and unplanned CBAS center closures

1. CalOptima Health shall ensure that DHCS and Members are notified in a timely manner of significant changes in the availability or location of covered services as described in CalOptima Health Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services resulting from but not limited to:

   a. Changes in hours, days, or location of which covered services are available; or

   b. Termination, suspension, decertification by the California Department of Aging.

2. Upon receipt of notification of CBAS center termination, suspension, decertification or unplanned closure:

   a. CalOptima Health LTSS Department shall request a list of Members enrolled in the CBAS center;

   b. LTSS Staff shall:

      i. Review the census report and verify the names and eligibility of Members enrolled in the CBAS center;

      ii. Send a written letter to the Member and/or Member's Authorized Representative of the center status;

      iii. Contact Member and/or Member's Authorized Representative by telephone to assess transfer preferences;

      iv. Identify appropriate CBAS center in the area for possible transfer and coordinate Members transfer to a new CBAS center of Member's choice.

      v. Notify the Regulatory Affairs and Compliance department when the Member's transition has been completed; and

      vi. Close the CBAS ARF for the discharging CBAS center upon verification of the Member's discharge and approve a new CBAS ARF for the receiving CBAS center.

3. Upon receipt of notification from a CBAS center of a planned closure, CalOptima Health LTSS Staff shall notify, within one (1) business day, the impacted CalOptima Health departments

such as, Contracting, Provider Network, Customer Service and Regulatory Affairs and Compliance departments and adhere the process outlined in section III.H of this Policy.

M. CalOptima Health will provide oversight of its contracted CBAS provider to ensure that they are meeting all the requirements in Department of Health Care Services All Plan Letter (APL) 22-020: Community-Based Adult Services Emergency Remote Services and CDA issued ACLs, in accordance with CalOptima Health Policy GG.1621: Community-Based Adult Services (CBAS) Quality Assurance and Site Visits.

N. CBAS Unbundled Services

1. For CalOptima Health Members who are CBAS eligible but who do not have access to a CBAS center due to center closures, the following shall apply:

   a. CalOptima Health shall identify the type, scope, and duration of the CBAS services the Member needs;

   b. The Member shall be assessed for possible enrollment in case management or care coordination, in accordance with CalOptima Health Policies GG.1301: Comprehensive Case Management Process and MA.6009: Care Management and Coordination Process;

   c. CalOptima Health shall arrange, through care coordination and case management, needed nursing services, and/or referral to IHSS for additionally needed personal care services;

   d. If the Member needs therapeutic services, CalOptima Health shall internally coordinate with the responsible Health Network for the authorization of these services;

   e. If the Member requires mental health services, CalOptima Health shall refer the Member to the appropriate mental health services program; and

   f. All services shall be coordinated through existing network affiliations and through use of CBAS.

IV. ATTACHMENT(S)

A. Authorization Request Form (ARF)
B. Benefit Inquiry for Community-Based Adult Services (CBAS)

V. REFERENCE(S)

A. California Department of Health Care Services – Community-Based Adult Services (CBAS) Eligibility Determination Tool (CEDT)
B. CalOptima Health Contract with the Department of Health Care Services
C. CalOptima Health Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services
D. CalOptima Health Policy EE.1103: Provider Network Training
E. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
F. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
G. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
H. CalOptima Health Policy GG.1508: Authorizations and Processing Referrals

I. CalOptima Health Policy GG.1600: Access and Availability Standards
J. CalOptima Health Policy GG.1621: Community-Based Adult Services (CBAS) Quality Assurance and Site Visits
K. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
L. CalOptima Health Policy GG.1828: Community Based Adult Services (CBAS) Reauthorization Process
M. CalOptima Health Policy GG.1829: Community-Based Adult Services (CBAS) Discharge Notification Process
N. CalOptima Health Policy HH.1102: Member Grievance
O. CalOptima Health Policy MA.2100: Telehealth and Other Technology-Enabled Services
P. CalOptima Health Policy MA.6021a: Continuity of Care for New Members
Q. CalOptima Health Policy MA.9002: Enrollee Grievance Process
R. California Department of Aging (CDA) CBAS Bureau All Center Letter (ACL) 22-04: Launch of New CBAS Emergency Remote Services (ERS)
S. Department of Health Care Services All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
T. Department of Health Care Services All Plan Letter (APL) 22-020: Community-Based Adult Services Emergency Remote Services
U. Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions: California CalAIM Demonstration
V. State of California Community-Based Adult Services Individual Plan of Care (IPC)
W. Title 42, Federal Code of Regulations, §139u-2(b)(2)(D), 422.566(c), and 422.568.
X. Welfare and Institutions Code, §§ 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e).

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/20/2012	Department of Health Care Services (DHCS)	Approved as Submitted
09/06/2012	Department of Health Care Services (DHCS)	Approved as Submitted
09/25/2012	Department of Health Care Services (DHCS)	Approved as Submitted
05/14/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/24/2021	Department of Health Care Services (DHCS)	Approved as Submitted
06/29/2021	Department of Health Care Services (DHCS)	Approved as Submitted
11/16/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/31/2023	Department of Health Care Services (DHCS)	Approved as Submitted
03/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2012	GG.1130	Community Based Adult Services (CBAS) Eligibility and Authorization Process	Medi-Cal
Revised	12/01/2014	GG.1130	Community Based Adult Services (CBAS) Eligibility and Authorization Process	Medi-Cal
Revised	05/01/2015	GG.1130	Community Based Adult Services (CBAS) Eligibility and Authorization Process	Medi-Cal
Revised	02/01/2016	GG.1130	Community Based Adult Services (CBAS) Eligibility and Authorization Process	Medi-Cal OneCare Connect
Revised	02/01/2017	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	06/01/2018	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	11/01/2019	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	08/01/2022	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare Connect
Revised	03/01/2023	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare
Revised	01/01/2024	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare
Revised	05/01/2024	GG.1130	Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
California Electronic Visit Verification (CalEVV)	A federally mandated telephone and computer-based application program that electronically verifies Medi-Cal funded personal care

Term	Definition
	services (PCS) and home health care services (HHCS) for in-home visits by a provider.
CBAS Eligibility Determination Tool (CEDT)	DHCS approved screening tool utilized by a Registered Nurse to assess if a Member meets eligibility criteria, medical necessity and therefore qualifies for Community-Based Adult Services.
Chronic Mental Disorder	One or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: 1. Pervasive Developmental Disorders; 2. Attention Deficit and Disruptive Behavior Disorders; 3. Feeding and Eating Disorder of Infancy, Childhood, or Adolescence; 4. Elimination Disorders; 5. Schizophrenia and Other Psychiatric Disorders; 6. Mood Disorders; 7. Anxiety Disorders; 8. Somatoform Disorders; 9. Factitious Disorders; 10. Dissociative Disorders; 11. Gender Identity Disorder; 12. Paraphilia; 13. Eating Disorders; 14. Impulse Control Disorders Not Elsewhere Classified; 15. Adjustment Disorders; 16. Personality Disorders; or 17. Medication-Induced Movement Disorders.
Community-Based Adult Service (CBAS)	An outpatient program that delivers Skilled Nursing Facility care, social services, therapies, personal care, family/caregiver training and support, nutritional services, transportation, and other services to eligible Members who meet applicable eligibility criteria.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Developmental Disability	A disability, which originates before the individual attains age eighteen (18), continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in Title 17 CCR § 54000.
Electronic Visit Verification	Federally mandated telephone and computer-based application program that electronically verifies in-home service visits.
Expedited Request	When nursing facility or hospital identifies a potential need for expedited CBAS services within the discharge plan.

Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	For purposes of this Policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Risk Assessment (HRA)	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
Hours of Service	The program hours for the provision of CBAS, which shall be no less than four (4) hours, excluding transportation.
Individual Plan of Care	For purposes of this Policy, a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law.
In-Home Supportive Services (IHSS)	Medi-Cal: Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Long Term Services and Supports (LTSS) Clinical Staff	Nurses who are considered to be the Registered Nurse (RN) Assessor and RN Quality Review Nurse pursuant to the definition from the Department of Health Care Services (DHCS).
Long-Term Services and Supports (LTSS) Staff	CalOptima Health Clinical and support staff. Support staff refers to the medical authorization assistants.
Member	A beneficiary enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.

Term	Definition
Non-Emergency Medical Transportation (NEMT)	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Nursing Facility-A (NF-A)	Level of care characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Personal Care Coordinator (PCC)	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare Connect and the Health Network (HN). The role of the PCC is to facilitate communication between the Member, CalOptima Health, the HN or CN, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.
Personal Care Services	Services supporting individuals with activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. and may offer support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.
Personal Health Care Provider	A physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, “Primary Care Practitioner” or “PCP” shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Requestor	A physician, nurse practitioner, health network providers, CBAS, other health care providers, Member, or Member’s family.
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the Department of Health Care Services (DHCS).