Policy:	GG.1828
Title:	**Community Based Adult Services (CBAS) Reauthorization Process**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	12/01/2014
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the Community Based Adult Services (CBAS) reauthorization process to ensure CalOptima Health CBAS-eligible Members continue to receive the CBAS benefit.

II. POLICY

A. CalOptima Health shall authorize CBAS services based on CBAS eligibility and Medical Necessity criteria pursuant to CalOptima Health policy GG.1130: Community Based Adult Services (CBAS) Eligibility and Authorization Processes.

B. CalOptima Health Long Term Services and Supports (LTSS) Clinical Staff shall be responsible for processing CBAS reauthorization requests for CalOptima Health and Health Network Members.

C. CalOptima Health shall utilize the Department of Health Care Services (DHCS) approved CBAS Eligibility Determination Tool (CEDT) to determine if the Member meets CBAS eligibility and Medical Necessity criteria requirements when the reauthorization request does not support the need for CBAS services.

D. CBAS centers must convene the Multi-Disciplinary Team (MDT) and update a Member's Individualized Plan of Care (IPC) at least every six (6) months, or as a Member's health condition changes.

E. CalOptima Health shall reassess and redetermine the Member's eligibility for CBAS services:

1. At least every six (6) months after initial assessment;

2. Up to every twelve (12) months for individuals determined by the managed care plan to be clinically appropriate; or

3. Whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.

F. A Member's IPC shall be:

1. Developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline;

2. A result of a collaborative process among the CBAS center, the Member, and/or Member's Authorized Representative(s);

3. Based on a Person-Centered Planning process; and

4. Based on assessment or reassessment conducted no more than thirty (30) calendar days prior to the start date of the IPC. If a CBAS center submits the IPC to CalOptima Health more than thirty (30) calendar days prior to the IPC effective date, the CBAS Provider must identify any change in condition requiring the IPC amendment prior to implementation of a new IPC.

G. A CBAS center must submit the CalOptima Health CBAS Authorization Request Form (ARF) and the most current IPC with the Level of Service (LOS) indicated to the CalOptima Health LTSS Department within thirty (30) calendar days before the expiration of the current active authorization.

1. CalOptima Health's LTSS Department may grant retroactive approval for CBAS ARFs for at least one (1) of the following conditions:

a. Certification of the Member's eligibility was delayed by the Orange County Social Services Agency (SSA);

b. Member's Primary Care Physician (PCP) failed to sign the Individualized Plan of Care (IPC) timely or a Member of the Multi-Disciplinary Team (MDT) is unavailable due to extenuating circumstances to complete the assessment or reassessment of Member.

c. The CBAS center was unable to submit a timely request for authorization or reauthorization for one (1) of the following reasons:

i. A natural disaster destroyed or damaged the center's business office or records or substantially interfered with the center agent's processing of the center's CBAS ARF.

ii. A delay due to other circumstances beyond the control of the center, which was reported to the appropriate law enforcement or fire agency, when applicable.

iii. Circumstances not considered beyond the control of the center include, but are not limited to:

a) Negligence of the employee;

b) Misunderstanding of program requirements;

c) Illness or absence of any employee trained to prepare CBAS ARFs;

d) Technology failure; or

e) Delays caused by the United States Postal Service, facsimile, or other private delivery service.

H. If a Member does not meet the CBAS eligibility and Medical Necessity criteria, CalOptima Health shall deny the request in accordance with CalOptima Health Policy GG.1508: Authorization and

Processing Referrals, and CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. CalOptima Health's Medical Director cannot deny, defer, or reduce a CBAS services request without LTSS Clinical Staff or contracted Providers performing a CBAS Eligibility Determination Tool (CEDT) Face-to-Face (F2F) assessment. A registered nurse (RN) shall perform the CBAS CEDT F2F assessment.

J. CalOptima Health shall not reimburse for "Carry Over" days.

III. PROCEDURE

A. To initiate the CBAS reauthorization process, CBAS centers must submit the following documents to the CalOptima Health LTSS Department:

1. CBAS Authorization Request Form (ARF);

2. Member's CBAS IPC with LOS, as recommended by the MDT to include:

a. Medical diagnoses;

b. Prescribed medications;

c. Scheduled days at the CBAS center;

d. Specific type, number of service units, and frequency of individual services be rendered on a monthly basis; and

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

f. Any changes to the Member's characteristics, including, but not limited to, living arrangements, level of independence, services and supports, or mental acuity.

3. Member's CBAS center MDT evaluation documents, as requested by the LTSS department; and

4. Medical history and Physical Exam (as requested by LTSS department).

B. A CBAS center shall submit a reauthorization request upon a change in a Member's health condition that requires a change in LOS prior to providing additional days of service.

C. CBAS centers shall submit the requested documents to the CalOptima Health LTSS assigned facsimile number.

D. If CalOptima Health determines the Member continues to meet CBAS eligibility and Medical Necessity criteria, and the IPC substantiates the LOS, CalOptima Health LTSS Clinical Staff shall review the request and notify the CBAS Center, and Member as follows:

1. Authorize, or deny, within five (5) business days from receipt of the reauthorization request;

2. Written notification of approval, or denial:

a. Within one (1) business day of decision to the CBAS center;

b. Within two (2) business days of decision to the Member.

3. If CalOptima Health is unable to make a decision within fourteen (14) calendar days, CalOptima Health LTSS Clinical Staff will send a written delay letter to the Member and the CBAS requestor via facsimile, when appropriate, in accordance with Health and Safety Code, Section 1367.01 and CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

E. If a Member's CBAS MDT evaluation and IPC do not substantiate the requested Level of Care (LOC), CalOptima Health LTSS Clinical Staff will send the Member's clinical information to CalOptima Health's Medical Director for review and determination. If CalOptima Health's Medical Director determines that the reauthorization request does not meet CBAS Medical Necessity criteria, and the request results in a modification, or a denial, CalOptima Health shall administer a new CEDT F2F assessment of the Member.

1. CalOptima Health LTSS Clinical Staff, or contracted Providers, shall administer a new CEDT F2F assessment within five (5) business days of the decision, but no later than fourteen (14) calendar days from the receipt of request. CalOptima Health LTSS Staff will send a written delay letter to the Member and the CBAS requestor in accordance with Health and Safety Code, Section 1367.01 and CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

2. Upon completion and receipt of the second CBAS CEDT F2F assessment:

a. CalOptima Health LTSS Clinical Staff shall review and approve the request for six (6) to twelve (12) months if the Member meets the CBAS Medical Necessity criteria.

b. If the Member does not meet CBAS Medical Necessity criteria, CalOptima Health LTSS Clinical Staff shall forward the Member's clinical information to CalOptima Health's Medical Director for review and determination. If CalOptima Health's Medical Director determines the Member does not meet CBAS Medical Necessity criteria, CalOptima Health's Medical Director shall modify, or deny, the CBAS reauthorization request, in accordance with this policy. Upon this action, CalOptima Health LTSS Staff shall send a Notice of Action (NOA) or Integrated Notice of Denial (INOD) to the Member and the requesting CBAS center to include information regarding Appeal and Grievance processes per Section III.D.2.a.and b of this policy.

3. If the Member does not meet CBAS Medical Necessity, CalOptima Health LTSS Clinical Staff shall provide care coordination and refer Members to Case Management, Complex Case Management, Disease Management, Health Education, and/or other community-based resources for services such as In-Home Supportive (IHSS), Multipurpose Senior Services (MSSP), or Program of All-Inclusive Care for the Elderly (PACE), as appropriate.

IV. ATTACHMENT(S)

A. CBAS Authorization Request Form (ARF)
B. CBAS Eligibility Determination Tool (CEDT)
C. CBAS Individual Plan of Care (IPC)

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

B. CalOptima Health Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
E. Health and Safety Code, §1367.01

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/19/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/29/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2014	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal
Revised	01/01/2016	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	01/01/2017	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	04/01/2018	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	07/01/2019	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	04/01/2020	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal
Revised	01/01/2024	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1828	Community Based Adult Services (CBAS) Reauthorization Process	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
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: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
Carryover Days	For purposes of this policy, a day of attendance that was authorized on the Treatment Authorization Request (TAR) for the previous calendar month, not attended by the Member, not reimbursed for, and subsequently attended as an extra day during the calendar month following the month in which authorized.
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.

Term	Definition
Community-Based Adult Services (CBAS)	Skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Developmental Disability	As defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability but shall not include other handicapping conditions that are solely physical in nature.
Health Risk Assessment (HRA)	Medi-Cal: An assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place. OneCare: A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Hours of Service	Program hours for the provision of CBAS, which shall be no less than four (4) hours excluding transportation.
Individualized Plan of Care (IPC)	A written plan designed to provide a Member, determined to be eligible for CBAS, with appropriate treatment, in accordance with the assessed needs of the Member.
In-Home Supportive Services (IHSS)	Services provided to Members by a county in accordance with the requirements set forth in W&I Code sections 12300 et seq., 14132.95, 14132.952, and 14132.956.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.
Level of Service (LOS)	Based on the patient's condition and the needed level of care, used to identify and verify that the patient is receiving care at the appropriate level.
Long Term Services and Supports (LTSS)	Medi-Cal: Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services. OneCare: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As

Term	Definition
	described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
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).
LTSS Staff	For purposes of this policy, refers to Clinical and support Staff. Support Staff refers to Medical Authorization Assistants.
Medical Necessity	For the purposes of this policy, 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 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, characterized by: 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; and b. Member also requires assistance or supervision with two (2) of the following ADLs/IADLs:

Term	Definition
	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.
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.
Multi-Disciplinary Team (MDT)	The CBAS center's team, comprised of professional staff from multiple skilled disciplines, responsible for comprehensively assessing the member and defining an Individualized Plan of Care specific to that member's abilities and preferences.
Person-Centered Planning	An ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences. Person Centered planning, includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member's functional level, support systems and continuum of care needs. Person Centered Planning is an integral part of Basic and Complex Care Management and discharge planning.
Primary Care Practitioner/Physician (PCP)	Medi-Cal: Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic. OneCare: 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.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.