Policy:	GG.1829
Title:	**Community Based Adult Services (CBAS) Discharge Notification Process**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 11/13/2024*
Effective Date:	12/01/2014
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Community-Based Adult Services (CBAS**)** discharge notification process and requirements.

II. POLICY

A. CBAS centers shall notify CalOptima Health of a Member's discharge in accordance with the terms and conditions as outlined in this policy.

B. On a quarterly basis, CalOptima Health shall report the reasons for Members' discharge from a CBAS center to the Department of Health Care Services (DHCS). CalOptima Health Long Term Services and Supports (LTSS) staff shall collect and record all reported CBAS discharge reasons and dispositions for Members assigned to CalOptima Health and its contracted Health Networks.

D. A CBAS center shall complete and send, via facsimile, the CalOptima Health "CBAS Member Discharge Plan/Discharge Reason" notification form for any CalOptima Health Member who is no longer receiving CBAS services at the center within five (5) business days of the Member's discharge. The reason for a Member's discharge from a CBAS center may include, but is not limited to:

1. A Member's or Member's Authorized Representative's request to discharge;
2. CBAS center multidisciplinary team (MDT) determines that Member is no longer appropriate for CBAS services;
3. Death of a Member;
4. Member receives other services such as assisted living, In-Home Supportive Services (IHSS), Multipurpose Senior Service Program (MSSP), Program of All Inclusive Care for the Elderly (PACE);
5. Member moved out of plan area;
6. Member transfers to another CBAS center;

7. Member is no longer eligible with CalOptima Health;

8. Member is too ill to attend, or requires a higher level of care, such as a Skilled Nursing Facility; or

9. Member is non-compliant with CBAS center recommendations, including poor attendance, described as not attending the number of authorized days, or not attending the CBAS center for over sixty (60) calendar days, without notification to the CBAS center and prior approval; and

10. Member's authorization has expired.

E. To ensure care coordination, a CBAS center shall develop a Discharge Plan of Care and provide a copy to CalOptima Health when the Member's CBAS services are terminated. The Discharge Plan of Care must include:

1. The Member's name and ID number;

2. The name(s) of the Member's Physician(s);

3. If applicable, the date the Notice of Action denying authorization for CBAS was issued;

4. If applicable, the date the CBAS benefit will be terminated;

5. Specific information about the Member's current medical condition, treatments, and medications;

6. Potential referrals for Medically Necessary Services and other services or community resources that the Member may need upon discharge;

7. Contact information for the Member's case manager; and

8. A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

F. A Member may be discharged to:

1. Long term care, or nursing facility placement;

2. Acute care hospital;

3. Board and care/assisted living;

4. Home; or

5. Another CBAS center of Member's choice.

III. PROCEDURE

A. Upon discharge of a Member, the CBAS center shall submit a completed CBAS Member Discharge Plan/Discharge Reason Notification Form to the CalOptima Health LTSS Department but no later than five (5) business days of the discharge via facsimile, or electronic mail.

B. Upon receipt of Member's Discharge Plan/Discharge Reason Notification Form, CalOptima Health LTSS clinical staff shall complete Member's care coordination as follows:

1. Notify the Member's Case Manager and/or Primary Care Physician (PCP), when applicable, within five (5) business days of receipt of discharge via facsimile, or electronic mail.

2. Contact the Member and provide referrals for Case Management, Complex Case Management, Disease Management, Health Education, and/or other community-based resources of services, such as In-Home Supportive Services (IHSS), Multipurpose Senior Services (MSSP), or Program of All-Inclusive Care for the Elderly (PACE), as appropriate.

C. When a Member or Member's Authorized Representative chooses to transfer to another CBAS center, the CBAS center currently authorized to provide services must notify CalOptima Health within five (5) business days prior to transfer, or as soon as the center is notified, by completing the CBAS Member Discharge Plan/Discharge Reason Notification Form and submitting it to the CalOptima Health LTSS Department via facsimile, or electronic mail.

1. Transfer requests may be received from a Member or Member's Authorized Representative, the new CBAS center or the discharging CBAS center;

2. Upon receipt of transfer request, CalOptima Health LTSS staff shall review Member's records to ensure that Member is eligible for transfer;

3. CalOptima Health LTSS staff shall request discharge summary from CBAS center currently authorized to provide services;

4. CalOptima Health LTSS staff shall close the CBAS Authorization Request Form (ARF) for the discharging CBAS center upon verification of the Member's discharge and approve a new CBAS ARF for the receiving CBAS center.

IV. ATTACHMENT(S)

A. CBAS Discharge Plan/Discharge Reason Notification Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. California Department of Aging CBAS Discharge Summary Report Instructions CDA 4008i

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/19/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/22/2023	Department of Health Care Services (DHCS)	60 Days No Response
10/31/2024	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	12/01/2014	GG.1829	CBAS Discharge Notification Process	Medi-Cal
Revised	01/01/2016	GG.1829	CBAS Discharge Notification Process	Medi-Cal OneCare Connect
Revised	01/01/2017	GG.1829	CBAS Discharge Notification Process	Medi-Cal OneCare Connect
Revised	05/01/2018	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare Connect
Revised	07/01/2019	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare Connect
Revised	04/01/2020	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare Connect
Revised	07/01/2021	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1829	CBAS Discharge Notification	Medi-Cal
Revised	06/01/2023	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare
Revised	10/01/2024	GG.1829	CBAS Discharge Notification	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
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.
CalOptima Health	For purposes of this policy, CalOptima Health shall include CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
Community-Based Adult Service (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.
Community-Based Adult Service (CBAS) Center	Adult day health center licensed, contracted, and certified to provide services to eligible older adults and/or adults with disabilities in accordance with California Welfare and Institutions Code Section 14552 and other applicable State regulations.
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 as provided by statute and/or regulation. .
Discharge Plan of Care	For purposes of this policy, a plan of care prepared by the CBAS Provider for Members who have been determined by Contractor or DHCS to no longer be eligible for CBAS and must include: 1. The Member's name and ID number. 2. The name(s) of the Member's physician(s). 3. Date the Notice of Action was issued. 4. Date the CBAS benefit will be terminated. 5. Specific information about the Member's current medical, condition, treatments, and medications. 6. A statement of how Enhanced Case Management services will be provided to the Member if eligible for these services. 7. A statement of the Member's right to file a Grievance or Appeal. 8. A space for the Member or the Member's representative to sign and date the Discharge Plan.

Term	Definition
Health Network	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.
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.
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. 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).
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.
Primary Care Practitioner/Physician (PCP)	Medi-Cal: 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.

Term	Definition
Skilled Nursing Facility (SNF)	Medi-Cal: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program. OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.