blue california
Promise Health Plan

Policy Title: Community Based Adult Services (CBAS)		POLICY #: 10.2.23 Line of business: Medi-Cal	
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Department Head: Sr. Director, UM		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 10/22**	

PURPOSE

To define the scope of coverage and authorization process for Community Based Adult Services (CBAS) for eligible adult individuals with intensive health care needs.

POLICY

Blue Shield of California Promise Health Plan (Blue Shield Promise) shall arrange for and approve the following Core or unbundled CBAS services for eligible adult members:
Core Services:

- Professional Nursing Services
- Personal Care Services
- Social Services
- Therapeutic Activities
- A meal

Additional CBAS Services:

- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology Services
- Mental Health Services
- Transportation Services
- Nutritional Counseling

DEFINITION:
Community Based Adult Services (CBAS) – an outpatient, facility based program that delivers skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible beneficiaries. This program took effect on April 1, 2012 under the California's "Bridge to Reform" 1115 Medicaid Waiver.
Adult Day Health Care (ADHC) Program – A licensed community-based day health care program that provided services to older individuals with chronic medical, cognitive, or mental health conditions and/or disabilities that are at risk of needing institutional care. This program ended on March 31, 2012.

CBAS Eligibility Determination Tool (CEDT) – an assessment tool used in determining eligibility for CBAS Services.

Individualized Plan of Care (IPC) – a written plan designed to provide the CBAS beneficiary with appropriate treatment and level of service in accordance with the assessed needs of the individual. The IPC is prepared by the CBAS Center's multi-disciplinary team.

Enhanced Case Management (ECM) – a service, consisting of "complex case management" and "person-centered planning," that includes the coordination of supports, including medical, social, educational and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the enrollees and/or designees.

PROCEDURE

Blue Shield Promise Referral Workflow and Timeframes for Community Based Adult Services:

I. New Candidates, Standard Process:

1. A potential need for CBAS services is identified and a referral is submitted to the Blue Shield Promise CBAS Team. Any of the following may refer a member for CBAS services:
    a. Community Based Organizations
    b. Physicians
    c. Nursing Facilities
    d. Hospitals
    e. Individuals Family Members
    f. CBAS Providers
2. For new referrals, Blue Shield Promise will require a current History & Physical or other supporting medical records from a physician to be attached for review.
3. Blue Shield Promise CBAS department/CBAS coordinators reviews the referral and applies CBAS pre-screen criteria:
    a. Medi-Cal eligible
    b. ≥ 18 years old
    c. Medi-Cal coverage is assigned to Blue Shield Promise
4. If the member does not meet pre-screening criteria, Blue Shield Promise CBAS department/CBAS coordinators will notify the requesting party and the member of ineligible status by mail within 5 business days.
5. If the member does meet the pre-screening criteria, a letter acknowledging receipt of the inquiry and eligibility for the Face to Face assessment (F2F) will be mailed to the requesting party and the member within 5 business days.
6. Blue Shield Promise/contracted home health schedules a F2F assessment with the member:
    a. Blue Shield Promise CBAS coordinators send the contracted home health agency referrals to begin the F2F process. The contracted home health agency makes the first attempt to contact the member or family within 5 business days of the initial referral. The contracted home health nurse coordinates and schedules the F2F meeting with member, family member, or caregiver.
    b. If unable to reach the member during the first attempt, the contracted home health nurse shall make two additional attempts via telephone between 5 and 8 business days of the initial referral to schedule the F2F.
    c. If still unable to reach the member after the three telephonic attempts, Blue Shield Promise CBAS coordinators will make a final attempt in writing. A notification/ "unable to reach" letter, giving the member until the 14th calendar day from when the request was received to schedule the F2F, shall be mailed to the member's primary residence.
    d. If the member does not respond or schedule the F2F within 14 days of the initial referral, Blue Shield Promise shall send a notification letter (same letter as unable

to reach) or referral closure to the member and requestor. The notice shall also indicate that if CBAS services are still being requested, then a new referral must be submitted to begin the process again.

e. If the member or the caregiver/family member is contacted on the first attempt, the F2F meeting is scheduled within 14 days from when request was received

7. The F2F eligibility assessment is completed using the CEDT tool within 30 calendar days from the date of the initial referral, utilizing the following:
    a. DHCS Community Based Adult Services (CBAS) CBAS Eligibility Determination Tool – CEDT Version 2.0
    b. DHCS Community Based Adult Services (CBAS) CBAS Eligibility Determination Tool-CEDT: Patient Health Record Quick Guide
    c. Other documentation required to determine eligibility may include:
        i. Current History and Physical signed by a physician or other licensed medical staff
        ii. Current Medication Record signed by a physician or a Nursing Med Sheet
        iii. Evidence of confirmed chronic mental illness in one or more diagnoses as set forth in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV TR, Fourth Edition, Text Revision (2000), published by the American Psychiatric Association
        iv. Evidence of a physician confirmed diagnosis of Alzheimer's Disease, Dementia, Traumatic Brain Injury or Organic Brain Injury
8. At Blue Shield Promise, the determination of eligibility and approval for services shall involve:
    a. Quality Assurance (QA)/CBAS case manager) reviewer conducts the initial review of the completed CEDT assessment tool
    b. QA reviewer may require a current History & Physical or other supporting medical records for review.
    c. 2nd level reviewer (Physical Reviewer) shall conduct the final review of the decision for the CBAS service request.
    d. Approval or denial of authorization for the CBAS provider to conduct the Individualized Plan of Care (IPC) is sent to the CBAS provider by FAX within 1 business day of decision.
    e. If approved for services, the member retains the right to remain or to choose another center at a later time.
9. If approved, the CBAS provider shall receive an authorization by FAX from Blue Shield Promise to conduct the IPC/Level of Service (LOS) assessment.
    a. The CBAS Multidisciplinary Team (MDT) shall perform the IPC assessment
    b. The CBAS provider shall then submit the prior authorization request to Blue Shield Promise along with the completed IPC as well as the LOS recommendation.
10. Blue Shield Promise/CBAS department adjudicates the prior authorization request from the CBAS provider through the following processes:
    a. Blue Shield Promise shall approve, modify, or deny the prior authorization request within 5 days, in accordance with Health and Safety Code, Section 1367.01.
    b. If Blue Shield Promise cannot make a determination within 5 business days, a 14-day delay letter shall be mailed to the member and the CBAS provider.
    c. Blue Shield Promise shall notify the CBAS provider by FAX within 1 business day of the decision. Blue Shield Promise CBAS department/CBAS Coordinators will mail a deferral letter of notification to the member within 2 business days of the decision.

CBAS provider may begin services upon receiving the FAX authorization.

II. For New Candidates, Expedited Process:

1. Nursing facility staff or hospital staff identifies a potential need for expedited CBAS services within the discharge plan and submits a request for inquiry to begin CBAS Assessment process.
2. Blue Shield Promise's contracted home health nurse makes an attempt to schedule a F2F assessment at the nursing facility or hospital with member/facility or facility or hospital with member/facility within 1 business day of receiving the referral.
    a. The F2F assessment is completed using the CEDT tool within 5 business days from the initial inquiry.
    b. Approval or denial of authorization for the CBAS provider to conduct the IPC is sent to the Center by FAX within 1 business day of decision.
    c. Member has the right to choose the center. Member may choose a CBAS center based upon personal preferences, geographic location, and cultural and linguistic needs.
3. At Blue Shield Promise, the determination of eligibility and approval for services shall involve:
    a. Quality Assurance reviewer conducts the initial review of the completed CEDT assessment tool.
    b. Quality Assurance reviewer may require a current History & Physical or other supporting medical records for review.
    c. 2nd level reviewer (Physician Reviewer) shall conduct the final review of the decision for the CBAS service request.
4. If approved, the CBAS provider shall receive an authorization by FAX from Blue Shield to conduct the IPC/LOS assessment.
    a. The CBAS Multidisciplinary Team (MDT) shall perform the IPC assessment
    b. The CBAS provider shall then submit the prior authorization request to Blue Shield of California Promise along with the completed IPC as well as the LOS recommendation.
5. Blue Shield Promise shall approve, modify or deny the prior authorization request within 3 business days, in accordance with H & S Code, Section 1367.01 (h) (2).
6. Blue Shield Promise shall notify the CBAS provider by FAX within 1 business day of the decision. Blue Shield Promise will mail a letter of notification to the member within 2 business days of the decision.

III. Existing CBAS Participants:

1. CBAS provider re-assesses the participant and submits to Blue Shield Promise: a prior authorization request, the participant's attendance records, for the past two months, along with an updated IPC and the LOS recommendation.
2. Blue Shield Promise/ CBAS case manager receives the prior authorization request from the CBAS provider and reviews the authorization request and the LOS recommendation through the existing authorization process.
    a. Blue Shield Promise shall approve, modify, or deny the prior authorization request within 5 business days, in accordance with H&S Code, Section 1367.01.
    b. If Blue Shield Promise cannot make a determination within 5 business days, a 14-day delay letter shall be mailed to the member and the CBAS provider.
    c. Blue Shield Promise shall notify the CBAS provider by FAX within 1 business day of the decision. Blue Shield Promise shall send a letter of notification to the member within 2 business days of the decision.
3. A F2F assessment prior to the determination of the reauthorization is not required for existing participants. However, Blue Shield Promise may request the F2F for reauthorization requests that lack sufficient supporting information for a determination to be made.

4. A F2F assessment shall be conducted for requests whereby Blue Shield Promise has determined that the LOS for the prior authorization request is to be decreased or denied.
5. CBAS services continue upon receipt of FAX authorization.

IV. Reassessment of Established CBAS Participant:

1. Every 6 months or when there is a change in the member's LOS, the CBAS provider shall update the IPC.
2. The CBAS provider submits an updated IPC, the participant's attendance records, for the past two months, along with the authorization request for a change in the approved LOS to Blue Shield of California Promise.
3. Blue Shield Promise reviews the prior authorization request and the IPC against established CBAS criteria.
4. If LOS criteria is met, Blue Shield Promise shall approve the authorization request within 5 business days.
5. If Blue Shield Promise cannot make a determination within 5 business days a 14-day delay/deferral letter shall be mailed by the CBAS department to the member and the CBAS provider and saved in the department folder.
6. Once a notice gets automatically triggered by MHC, Blue Shield Promise shall notify the CBAS provider by FAX within 1 business day of the decision. Blue Shield Promise shall mail a letter of notification to the member within 2 business days of the decision.
7. CBAS services begin
8. If the request no longer meets, eligibility criteria, the member has the option of being enrolled in other Blue Shield Promise eligible programs.
9. If the member agrees to participate in other Blue Shield Promise eligible programs, Blue Shield Promise Social Services Staff will conduct an ongoing assessment for changes in the members functioning status and health condition.
10. If determined to be appropriate, the Blue Shield Promise staff shall refer the member for a new F2F assessment to determine eligibility for CBAS.

V. CORE Services:

The following are examples of each of the core services that CBAS Centers are required to provide to each participant during each day of the participant's attendance at the center:

1. One or more of the following (5) professional **nursing services:**
    a. Observation, assessment, and monitoring of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition/s upon which admission to the CBAS Center was based.
    b. Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications and interventions, as needed.
    c. Oral or written communication with the participant's personal health care provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms.
    d. Supervision of the provision of personal care services for the participant and assistance, as needed.
    e. Provision of skilled nursing care and intervention, within scope of practice to participant, as needed.
2. One or both of the following **personal care services:**
    a. Protective group supervision and interventions to assure participant's safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.
    b. Supervision of, or assistance with activities of daily living or instrumental activities of daily living.

3. One or more of the following **social services** provided by the social worker or social worker assistant:
    a. Observation, assessment, and monitoring of the participant's psychosocial status;
    b. Group work to address psychosocial issues
    c. Care coordination
4. At least one of the following **therapeutic activities** provided by the CBAS center activity coordinator or other trained personnel:
    a. Group or individual activities to enhance the social interaction, encourage physical exercise, or improve cognitive functioning of the participant to prevent deterioration;
    b. Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.
5. One meal per day of attendance, unless the participant declines or medical contraindications exist.

VI. **Additional services are provided as specified:**

a. Rehabilitation Therapy – physical therapy, occupational therapy, speech therapy
b. Mental health services
c. Nutrition services – registered dietician for dietary counseling and nutritional education for the participant and/or family
d. Podiatry services
e. Optometry screening by a licensed ophthalmologist or optometrist
f. Dental screening
g. Transportation services
h. Other services, as approved by the department

VII. Determining Eligibility for CBAS Services:

To be eligible for adult day health care services, the person must meet all of the following criteria:

1. The person is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health condition, and the health care provider requested adult day health care services for the person.
2. The person has functional impairments in 2 or more activities of daily living, instrumental activities of daily living or one or more of each, and requires assistance or supervision in performing these activities.
3. The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.
4. The person requires adult day health care services that are individualized and planned, including coordination of services outside the adult day health care program
5. Any person who is a resident of an intermediate care facility who has disabilities and a level of functioning, that without supplemental intervention, placement to a more costly institutional level of care is likely to occur.

VIII. Categories for CBAS Eligibility:

1. **Category I**
    a. Individuals who meet NF-A Level of Care or above AND have met ADHC eligibility and medical necessity criteria stated in W&I Code Sections 14525 and 14526 and Nursing Facility-A (NF-A) Level of Care as set forth in Title 22, Sections 51120(a) and 51334(1) of the California Code of Regulations. Individuals who live in non-

medical residential care facilities (board and care facilities), or who live at home, will not be precluded from meeting this level of care.

b. Members that meet NF-B level of care as set forth in 22 Cal. Code of Regulations §513340 and §51124 will be presumed to be eligible. Esther Darling, et al. v. Toby Douglas, et al., Case No. C-09-03798 SBA Section(s) VI, 16.

2. Category II

a. Have been diagnosed by the physician as having an organic, acquired, or traumatic brain injury, and/or have a chronic mental illness AND meet ADHC eligibility and medical necessity criteria contained in W&I Code, Sections 1455 and 14526, AND demonstrate a need for assistance or supervision with at least (2) of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene, or (1) ADL/IADL listed above and money management, accessing resources, meal preparation, or transportation. Esther Darling, et al v. Toby Douglas, et al., Case No. C-09-03798 SBA Section(s) VI, 16 and X,B.

3. Category III

a. Individuals with Alzheimer's Disease or other Dementia AND have met ADHC eligibility and medical necessity criteria contained in W&I Code, Sections 14525 and 14526. Esther Darling, et al v. Toby Douglas, et al., Case No. C-09-03798 SBA Section(s) X,C.

4. Category IV

a. Individuals with Mild Cognitive Impairment including Moderate Alzheimer's Disease or Other Dementia AND have met the ADHC eligibility and medical necessity criteria contained in W&I Code, sections 14525 and 14526 AND demonstrate a need for assistance or supervision with at least (2) of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene. Esther Darling, et al v. Toby Douglas, et al., Case No. C-09-03798 SBA Section(s) X,D.

b. CBAS Record of Dementia Stages for CBAS Screening –Attachment A

c. The definition and information below from DHCS Guide to Determine Alzheimer Disease or Dementia Stages for CBAS Screening retrieved from: Attachment B

5. Category V

a. Individuals who have developmental disabilities and meet the criteria for Regional Center eligibility AND have met the ADHC eligibility and medical necessity criteria contained, et al. v. Toby Douglas, et al., Case No. C-09-03798 SBA Section(s) X,E.

IV. Levels of Medical Necessity Criteria:

1. Medical Necessity Level 1 – Assess needs for chronic qualifying conditions. The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified as requiring one or more of the following, without which the participant's condition will likely deteriorate:
    a. Monitoring
    b. Treatment
    c. Intervention
2. Medical Necessity Level 2 – identify ADL/IADL compromises (for category 2 or 4 only)
    a. Limitations in the performance of 2 or more activities of daily living or instrumental activities of daily living or one or more from either ADLs or IADLs.
    b. A need for assistance or supervision in performing the activities identified as related to the condition or conditions that qualify the participant for ADHC. The assistance or supervision shall be in addition to other non-adult day health care support the participant is currently receiving in his or her place of residence.

3. Medical Necessity Level 3 – Identify Community Supports. The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, as demonstrated by at least one of the following:
    a. Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
    b. Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.
    c. Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
4. Medical Necessity Level 4 – Identify Risk for Institutionalization
    a. A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner that if adult day health care services are not provided, would likely result in ER visits, hospitalization or other institutionalization.
5. Medical Necessity Level 5 – Identify need for daily CBAS services
6. Medical Necessity Level 6 – Determine Eligibility Outcome

V. Individual Plan of Care (IPC):

1. The IPC should 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 to be rendered on a monthly basis
    e. Elements of the services which need to be linked to individual objectives, therapeutic goals and duration of services
    f. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities
    g. Participation in specific group activities
    h. Transportation needs, including special transportation
    i. Special diet requirements, dietary counseling and education, if needed
    j. A plan for any other necessary services that the CBAS center will coordinate.
2. IPCs shall be reviewed and updated no less than every six months by the CBA staff, the enrollee, and his/her support team. Review shall include review of progress, goals, objectives, and the IPC itself.

VI. Level of Service (LOS) Adjudication:

Blue Shield Promise's adjudication process for the level of service considers the following factors:

1. Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days.
2. Frequency of services needed.
3. The extent to which other services currently being received by the recipient meet the recipient's needs.
4. For existing participants, the attendance record for the previous authorization period.
    a. If the personal healthcare provider or CBAS physician has requested a specific number of days. When requesting the number of days per calendar month, the provider must ensure the request is related to the participant's problems and the number of days needed to carry out the individualized plan of care (IPC).
5. Treatment needs of the participant shall determine the frequency and duration of attendance. The number of days scheduled shall be governed by the least time needed

to carry out an individual plan of care related to the needs of the participant and his or her family 22 CCR §54223 (a).

6. Participants shall not be encouraged to attend more frequently than necessary for achievement of individual goals and objectives. 22 CCR §54223 (b).

Initial and subsequent treatment authorization requests may be granted for up to six (6) calendar months.
Participation in an adult day health care program is voluntary. The participant may end the participation at any time; however, an adult day health care center shall not otherwise terminate the provision if services to any participant unless approved by the State Department.

VII. Enhanced Case Management:
People who are not eligible for CBAS will be assisted with obtaining Enhanced Case Management Services. These are services that may be available in the member's community or provided under the member's health plan benefits. Members deemed as no longer eligible for CBAS services will be transitioned from the CBAS services by referring them to a Blue Shield Promise ambulatory case manager. The case manager will perform an individual assessment of the member's needs and coordinate any arrangements the member may be eligible for.
Services may include:

- Mental health services
- Home delivered meals
- Personal care
- Medications
- Nurse Advice Line
- In Home Support Services
- Help finding Wheelchairs, Walkers, Blood Pressure Monitors, and Scales
- Physical or Occupational Therapy
- Urgent Care Needs
- Behavioral Health Services
- Non-Emergency Transportation

REFERENCES

- Welfare and Institutions Code
  - Section 14550-14551
  - Section 14525(a), (c), (d) and (e)
  - Section 14526.1 9(d)(1), (3), (4), (5) and (e)
  - Section 14527
- CA Bridge to Reform Demonstration Waiver, Special Terms and Conditions
- Darling, et al. vs Douglas Settlement Agreement, Care # C-09-03798 SBA
- CM P&P Complex Case Management 10.4.3
- DSM-IV Criteria for Diagnosis of Dementia of the Alzheimer's Type
- American Academy of Neurology: Detection, Diagnosis and Management of Dementia
- Agency for Healthcare Research and Quality