ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Alliance follows Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS) as well as for periodic reassessments of eligibility determinations.

Alameda Alliance for Health (AAH) ensures the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Ensures appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS is trained by DHCS on using the approved assessment tool.
B. Conducts the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations include a face-to-face or Telephonic review of the Member. The assessment team includes a Registered Nurse with level of care experience, either as an employee or as a sub- contractor.
C. AAH shall reassess and re-determine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.
D. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, AAH may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

E. AAH shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. AAH's written notice shall be approved by DHCS and include procedures for grievances and appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6, (Member Grievance and Appeal System.)
F. AAH shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

PROCEDURE

The Alliance Out of Plan team receives a CBAS-interest call from the following sources:

- Self, family and/or caregiver
- Primary Care Provider (PCP)
- Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
- CBAS provider/center
- Home or Community-Based Organization (HCBO)
- Acute care hospital (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)
- Skilled nursing facility, acute-care facility (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)

The Alliance CBAS Out of Plan RN contacts the member/authorized representative to confirm interest in CBAS services and ascertain administrative eligibility. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.

If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.

When the Alliance receives a referral for eligibility determination the following processes occur, although the ordering of the processes may vary according to individual cases:

1. Alliance CBAS team receives initial referral of a member to CBAS.

i. The Alliance acknowledges initial referral in writing to CBAS provider and to member within five (5) calendar days of initial referral.

ii. Out of Plan RN makes first attempt to schedule Face-to-Face assessment within 5 calendar days of initial referral.

   a. the RN makes two additional attempts via telephone to schedule between five (5) and eight (8) calendar days of initial referral

   b. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.

   c. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

iii. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:

   a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

i. Denial of CBAS program:

   a. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.

   b. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.

   c. Grievance and Appeals

      - A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
      - A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approval of CBAS program:

   a. Eligibility determination is communicated to the member and her/his

authorized representative within two (2) business days.

b. Authorization to conduct Individual Plan of Care (IPC) is communicated to the member's chosen CBAS provider within one (1) business day of the decision.

At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

5. CBAS center staff:

i. Performs three (3) day multidisciplinary team assessment.

ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation

iii. Submits a Prior Authorization request to the Alliance.

6. The Alliance:

i. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.

a. If the Alliance cannot make a decision within five (5) working days of receiving the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.

b. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, Independent Medical Review, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day.

c. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approved services are authorized for a six-month period.

a. Member is notified within 2 Business Days of authorization.

b. Center is notified within 1 Business Dayof authorization.

7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.

i. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in circumstances occurs that may require a change in the member's CBAS benefit.

ii. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

iii. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

iv. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

   a. The Member's name and ID number
   b. The name(s) of the Member's Physician(s)
   c. If applicable, the date of the Notice of Action denying authorization for CBAS was issued
   d. If applicable, the date the CBAS benefit will be terminated
   e. Specific information about the Member's current medical condition, treatments, and medications
   f. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge
   g. Contact information for the Member's case manager
   h. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

v. Communication and Coordination of Care

   a. AAH will coordinate with the CBAS provider to ensure:
      - Timely exchange of the following coordination of care information:
      - Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
      - Clear communication pathways between the appropriate CBAS Provider and staff and AAH staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.
   b. AAH will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in AAH policies and procedures related to CBAS.

DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care

coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long Term Care

RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 4/9/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4

MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn- around-time.