ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	CBAS-002
Policy Name	Expedited Initial Member Assessment 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	MCAL
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Alliance follows the Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS). Services are provided according to a six-month individual plan of care (IPC) developed by the CBAS center's multidisciplinary team (MDT) in collaboration with the CBAS participant or authorized representative(s). The services are designed to prevent premature and unnecessary institutionalization and to keep participants as independent as possible in the community. The Alliance has developed and implemented an expedited assessment process to determine CBAS eligibility when the plan is informed that a member is in a hospital or skilled nursing facility whose discharge plan includes CBAS, who is at high risk of admission to a skilled nursing facility, or faces an imminent and serious threat to their health, in accordance with Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) Section V.A.23.b
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PROCEDURE

1. If Alliance staff receives an initial CBAS referral for a member who is in the hospital or nursing facility and whose discharge plan includes CBAS, or for a member who is at immediate risk of admission to a nursing facility or faces an imminent and serious threat to their health, an expedited CBAS eligibility determination by the Alliance CBAS Out of Plan Nurse is triggered. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that a Face to Face (F2F) will not be performed:
    i. Members in a hospital or skilled nursing facility whose discharge plan includes

CBAS, who is at high risk of admission to a skilled nursing facility or faces an imminent and serious threat to their health or faces an imminent and serious threat to their health will have an expedited authorization within 72 hours of receipt of a CBAS authorization request.

ii. Written documentation of medical necessity is obtained from the Attending Physician.

iii. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

iv. The Alliance uses the Department of Health Care Services (DHCS) approved CBAS Eligibility Determination Tool (CEDT) tool. The CEDT is completed within 5 business days from initial referral (See Attachment A).

2. Eligibility determination is communicated to the member and her/his authorized representative within one (1) business day. If the requester and the member has not yet chosen or been assigned to a CBAS provider, the member and/or authorized representative may do so at this time.
   i. A denial of CBAS eligibility will result in a Notice of Action 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 Requester also receives a copy of this letter.
3. Approval or denial of eligibility is communicated to the CBAS center within one (1) business day of decision. At this point, if the member is approved for CBAS services, the Alliance authorizes the CBAS center to conduct a three (3) day interdisciplinary team assessment in order to produce an Individualized Plan of Care (IPC).
4. After the three-day assessment is completed, the CBAS center submits the IPC with Level of Service recommendation and a prior authorization request to the Alliance.
   i. The Alliance approves, modifies, or denies prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)
   ii. The Alliance notifies the Center within 24 hours of the decision. The Alliance notifies the member within 48 hours of the decision
   iii. If the prior authorization request is approved, CBAS services areapproved with specified level of service. Services are authorized for a six-month period and CBAS services begin.
   iv. If prior authorization request is denied, a Notice of Action 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 Requester also receives a copy of this letter.

DEFINITIONS / ACRONYMS

"Attending Physician" shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law and who is providing medical care to a Member.

"Case Manager" refers to a professionally trained and licensed Alliance staff member in the Case and Disease Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems more effectively with the aim of improving health status and reducing the need for medical services. The Case

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

Community Based Adult Services (CBAS): means 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 CalAIM Demonstration, Number 11-W-00193/9 Special Terms and Conditions

"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)"** a written plan of care developed by a CBAS center's multidisciplinary team 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 includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

CBAS Provider: means an ADHC center that is licensed by the California Department of Public Health to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a CBAS Provider by the California Department of Aging

"**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

Commented [RR1]: Please review and add in any other affected departments or parties

RELATED POLICIES AND PROCEDURES

None

Commented [RR2]: Please list all related P&Ps here - if there are none then please write "none"

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CBAS Eligibility Determination Tool (CEDT)

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 3/19/2024, 4/15/2024

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4
DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01
Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012

MONITORING

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