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	Outpatient Utilization Management
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 (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

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 (Alliance) 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. The Alliance 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, The Alliance may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

E. The Alliance 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. The Alliance'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. The Alliance 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. 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.

ii. 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 Day of 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. The Alliance 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 The Alliance 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. The Alliance will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in The Alliance 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, 9/25/2024, 12/18/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

DHCS CBAS Contract, Exhibit A, Attachment 20.4

DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01

MONITORING

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

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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	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

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 are approved 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

RELATED POLICIES AND PROCEDURES

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, 7/17/2024

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.

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POLICY AND PROCEDURE

Policy Number	CBAS-005
Policy Name	Provision of Unbundled CBAS Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	8/21/2024

POLICY STATEMENT

The Alliance provides unbundled Community Based Adult Services (CBAS) to Members who have been determined eligible for CBAS services when there is not sufficient and/or appropriate CBAS center capacity available within the timely access requirements. The Alliance does the following to ensure the provisions of unbundled CBAS services are met:

1. Arranges for the provision of unbundled services based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area.
2. Coordinates care for unbundled CBAS, based on the assessed needs of the member eligible for CBAS, including services beyond those offered as CBAs unbundled services

PROCEDURE

1. Members who have expressed interest in CBAS services and have been determined to meet medical necessity criteria will undergo CBAS eligibility determination (CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility)
2. When a Member has been determined eligible for CBAS services, the Member may select the CBAS center of their choice or be assigned to a CBAS center by the Alliance (see Policy and Procedure entitled CBAS-004 Member Assignment to a Community-Based Adult Service (CBAS) Center).
3. If an appropriate CBAS center exists in the service area but is at full capacity, the Member may be on a waitlist and contacted when an opening becomes available, at which

time that Member will undergo multidisciplinary assessment by the CBAS center (See Policy and Procedure entitled CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility. If there is no appropriate CBAS center available or if the member is placed on a waitlist, the Member may choose to accept a program designed by the CBAS RN as described inCalifornia Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

. The Alliance follows our Special Needs Plan (SNP) Model of Care which outlines the "Development of the Individualized Care Plan (ICP) for High Risk Members" as well as follow-up action and regularity of Interdisciplinary Care Team (ICT) meetings.

4. The Individualized Care Plan (ICP) outlines a package of unbundled services that might otherwise be provided at a CBAS center. These services are limited to:
    a. Professional Nursing Services
    b. Nutrition
    c. Physical Therapy
    d. Occupational Therapy
    e. Speech and Language Pathology Services
    f. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service provider
    g. Non-Specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) that are Covered Services.
5. Coordination of care for unbundled CBAS services, based on the assessed needs of the member, may include services beyond those offered as CBAS unbundled services, including but not limited to:
    a. Personal Care Services
    b. Social Services
    c. Physical and Occupational Maintenance Therapy
    d. Meals
    e. Mental Health Services and Substance Use Services.
6. Reevaluation of Member needs and update of the ICP occurs annually.
7. If a new CBAS center opens and is appropriate for a particular member's needs, the member is referred to that CBAS center for a multidisciplinary assessment and a service authorization request will progress (see Policy and Procedures entitled CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility)

DEFINITIONS / ACRONYMS

"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.

"Community-Based Adult Services (CBAS) center" shall mean a Provider that provides skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Members and is certified by the California Department of Aging.

"Core CBAS services" shall mean services that are designed to maintain the ability of a CBAS participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization and are required on each CBAS attendance day.

They include professional nursing services, personal care services and/or social services, therapeutic activities, and meal service.

"Individualized Care Plan (ICP)" is the initial and ongoing document which delineates a Member's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives.

"Interdisciplinary Care Team (ICT)" is a multiagency, multidisciplinary healthcare team which is person centered in its approach, led by a Members primary care Provider.

"Member" shall mean any person certified as eligible for the Medi-Cal Program, pursuant to Welfare and Institutions Code, Sections 14016 and 14018, whose designated County Code number in the Medi-Cal Eligibility Data System (MEDS) database is "41 and Plan number 503", and whose Aid Code is included for capitation payment in the Alliance's contract with the State of California.

"Specialized CBAS services" shall mean services that may be included in a CBAS ICP and are designed to maintain the ability of a CBAS participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization but are not required for every participant on every day of service. They include rehabilitative services, registered dietitian services, and mental health services.

"Special Needs Plan (SNP)" is a specially designed Medicare Advantage health plan. Enrollment is focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual eligible members, and beneficiaries the severe or disabling chronic conditions.

"Special Needs Plan (SNP) Model of Care" refers to a service delivery mechanism required and approved by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plans. The Model of Care contains the following elements: measurable goals, staff structure and care management roles, interdisciplinary care team, Provider network having special expertise, use of clinical practice guidelines, specialized training, health risk assessment, communication network, performance, and health outcome measurements.

AFFECTED DEPARTMENTS/PARTIES RELATED POLICIES AND PROCEDURES

CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
CBAS-002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility
CBAS-004 Member Assignment to a Community-Based Adult Service (CBAS) Center

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REVISION HISTORY

10/1/2013, 09/06/2018, 04/15/2019, 5/21/2020, 5/20/2021, 06/28/2022, 6/20/2023, 8/21/2024

RELATED WORKFLOW DOCUMENTS OROTHER ATTACHMENTS

~~CBAS Determination of Eligibility Tool (CDET)~~

REFERENCES

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	CBAS-006
Policy Name	CBAS Emergency Remote Services (ERS)
Department Name	Health Care Services – OP UM
Department Officer	Chief Medical Officer
Policy Owner	UM Director
Line(s) of Business	MCAL
Effective Date	7/17/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver, authorized by the Centers for Medicare and Medicaid Services (CMS) now includes the provision of community-based adult services emergency remote services (CBAS ERS) after cessation of Temporary Adult Services (TAS) to ensure each member's needs continue to be met if the member is unable to return physically to a CBAS center for services. The goal is to support Seniors and Persons with Disabilities and their families and caregivers where and when services are needed. This expands access to home and community-based services to support individuals remaining in their homes and communities. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings in the community, the participant's home or via telehealth to allow for immediate response during CBAS participant emergencies.

CBAS ERS is available only to CBAS participants. CBAS participant is defined as:

- Member eligible for CBAS by the managed care plan (MCP)
- Has completed a person-centered care plan
- Has an approved authorization on file AND
- Signed a CBAS participation agreement at the CBAS Center

There are two (2) unique circumstances that may result in need for ERS services. The provision of ERS supports and services is temporary and time-limited, and specifically either:

1.**Short-term:** Members may receive ERS for an emergency occurrence for up to three consecutive months. CBAS providers and MCPs must coordinate to ensure duration of ERS is appropriate during the Member's current authorized period and, as necessary, for reauthorization into a new period; or

2. **Beyond Three Consecutive Months**: ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and MCPs must coordinate on requests for authorization of ERS that exceed three consecutive months.

The two types of circumstances in need for ERS are:

A. Public Emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc.

B. Personal Emergencies, such as serious illness or injury, crises, or care transitions, as defined below. Specific personal emergencies may include serious illness or injury, crises, care transitions such as to/from a nursing facility, hospital, and home.

- Serious Illness or Injury means that the illness or injury is preventing the Member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain.
- Crises means that the Member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises would be the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
- Care Transitions means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and Member/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

Members may choose to cease receipt of ERS at any time. The Alliance will cover ERS as part of the CBAS benefit when a member meets the criteria established as outlined above.

CBAS providers are required to obtain expanded licensure to add ERS as an Optional Service to their respective center. The Alliance Operations designee will ensure that their contracted CBAS providers meet all operational requirements as outlined in APL 22-020 and the California Department of Aging (CDA) All Center Letters ACL 22-04 Launch of CBAS Emergency Remote Services and completion and licensure approval for these expanded services.

The Alliance will collaborate with all CBAS providers to ensure that each member's needs continue to be met, whether through in-person services provided at the CBAS center or through ERS and that the member's needs are documented appropriately on the CDA 4000i form and interdisciplinary plan of care (IPC). For members who choose to discontinue their CBAS services, the Alliance will ensure care coordination occurs for these members and that their continued needs are met.

ALAMEDA Alliance FOR HEALTH

PROCEDURE

1. The CBAS Center identifies emergency services needs for a member
    a. Public (earthquake, flood, fire, power outages, epidemic/infectious disease outbreak)
    b. Personal (serious illness, crisis, care transition)
    c. Additional circumstances may include: hospitalization, loss of housing, personal health care provider restrictions, loss of caregiver, nursing home admission

2. The CBAS Center completes the CBAS ERS Initial CDA (California Department of Aging) 4000i CBAS ERS initiation form (CEIF) via the Peach Portal within 3 business days from the date of identification of the emergency. Up to 7 business days allowed for completion of the CEIF in cases of widespread emergency affecting the majority (50% or greater) of the participants enrolled at the center at the time of the emergency:

3. The Center submits the completed CDA 4000i CBAS ERS form to the Health Plan within the same time constraints noted above.

4. The CBAS RN will:
    a. Review the request against the criteria outlined in APL 22-020 Community-Based Adult Services Emergency Remote Services
    b. Assess for any case management or care coordination needs in addition to services provided during ERS to ensure that the member's needs are met, and the member is safely managed during their emergency remote period. The Plan will collaborate with the CBAS center to confirm any identified needs and how needs will be managed.
    c. Complete the CBAS ERS note type
    d. Upon decision the nurse will forward the case to the CBAS coordinator for creation of authorization and notification to applicable parties. The authorization represents the Plan's agreement for ERS services as submitted by the Center.
5. The coordinator will:
    a. Add the request to the current active IPC authorization
    b. Attach the completed form to the document section of the members account
    c. Notify applicable parties per normal process

6. The member my choose to cease receipt of ERS at any time

7. The initial authorization will be for no more than 90 days with a one-time extension for an additional 3 months if the member continues to meet the ERS criteria for services. Participants will be reassessed by the Center inter disciplinary team and submit and updated plan for continued remote/telehealth delivery of CBAS services. CBAS Centers will submit the extension request via fax for review and re-authorization as outlined above.

8. Ongoing services will be reviewed based on the AAH IPC reassessment policy outlined in CBAS-001

9. Members who are discharged from the CBAS program will have a CBAS Discharge Plan of Care completed by the CBAS Center outlining a member's continued care needs. The MCP CBAS RN will:
    a. Collaborate with the Center to identify any additional CM or care coordination needs for the member
    b. The CBAS RN will work with the MCP CM team to coordinate services with applicable providers to secure the needed services

DEFINITIONS / ACRONYMS

CalAIM: California Advancing and Innovating Medi-Cal

CMS: Centers for Medicare and Medicaid Services

CBAS ERS: Community-Based Adult Services Emergency Remote Services

CDA 4000i CEIF: California Department of Aging CBAS Emergency Remove Services Initiation Form

IPC: Interdisciplinary Plan of Care

MCP: Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

Case Management

RELATED POLICIES AND PROCEDURES

CBAS -001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy: 7/17/2024

REFERENCES

1. APL 22-020 Community-Based Adult Services Emergency Remote Services
2. California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver
3. CDA 4000i CBAS ERS form

MONITORING

1. Internal Reporting development for CBAS/CBAS ERS, reported at UMC
2. Quarterly CBAS Departmental Auditing