KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br><br>POLICY AND PROCEDURES | | | | | |
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| SUBJECT: Community Based Adult Services Program | | | | POLICY #: 3.99-P | |
| DEPARTMENT: Utilization Management | | | | | |
| Effective Date:<br>05/30/2024 | Review/Revised Date:<br>05/30/2024 | DMHC | | PAC | |
| | | DHCS | X | QI/UM COMMITTEE | |
| | | BOD | | FINANCE COMMITTEE | |

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Utilization Management

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Population Health Management

_____ Date _____
Director of Claims

**PURPOSE:**

Kern Health Systems (KHS) serves to implement a comprehensive integrated process that adheres to Community-Based Adult Services (CBAS) services. In accordance with:

A. California Department of Health Care Services Managed Care Operations Division Kern Health Systems 22-20201 Exhibit A Scope of Work Contract Provisions
B. California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs), including Sections VIII.A.19 through 30 and Attachments H and S,

or in accordance with any subsequent Demonstration amendment or renewal or successive Demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

C. California Department of Health Care Services Medi-Cal Provider Manual Part 2 CBAS Services
D. CBAS centers offer a package of health, therapeutic and social services in a community-based day health care program. 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.

**CBAS Objectives**

The primary objectives of the CBAS program are to:

A. Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
B. Delay or prevent inappropriate or personally undesirable institutionalization.
C. The program stresses collaboration with the member, the family and/or caregiver, the primary care provider (PCP), and the community in working toward maintaining personal independence.

**POLICY:**

Kern Health System (KHS) will implement Home and Community Based Services (HCBS) Waiver Programs in compliance with DHCS Contract Exhibit A – Attachment 11 HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in Title 22 CCR Sections 51184, 51340 and 51340.1.

KHS will arrange and coordinate CBAS services for KHS Medi-Cal eligible members 18 years or older and meet the qualifications of CBAS eligibility criteria.

CBAS Service coordination will be conducted by the KHS CBAS-RN.

KHS shall contract with sufficient available CBAS providers in the KHS covered geographic service areas to address in a timely way the needs of members who meet the CBAS eligibility criteria in STC 19(d).

Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs, and preferences.

KHS will confirm that every contracted CBAS provider meets the KHS' credentialing requirements including but not limited to, current and active licensure, certification, and enrollment in the DHCS Medi-Cal Fee-For-Service Program.

KHS may exclude or terminate, at its discretion, any CBAS provider that does not meet the plan's credentialing requirements, Medi-Cal enrollment status, and/or quality standards pursuant to KHS

Policy and Procedures as required by the contractual agreement with KHS, or otherwise ceases its operations as a CBAS provider.

KHS will provide the Department of Health Services a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

KHS shall arrange for and approve the following Core or unbundled CBAS services for eligible adult members:

Core Services:

A. Professional Nursing Services
B. Personal Care Services
C. Social Services
D. Therapeutic Activities
E. A meal
F. Family and/or caregiver training and support

Additional CBAS Services:

A. Physical Therapy
B. Occupational Therapy
C. Speech and Language Pathology Services
D. Mental Health Services
E. Transportation Services
F. Nutritional Counseling

KHS will adhere to CBAS Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to every six (6) months after initial assessment and every twelve (12) months for individuals determined by KHS to be clinically appropriate.

KHS shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another. Please refer to KHS UM P&P 3.40 I Titled "Continuity of Care for New Members".

In the event that CBAS services are no longer available or reach capacity in a given location, KHS Shall arrange CBAS-like services to those members that meet the eligibility criteria.

KHS complies with applicable Federal Civil Rights Laws and does not discriminate, exclude people, or treat them differently on the discriminating based on race, color, national origin, religion, ancestry, ethnic group identification, sex, gender identity (including gender expression), sexual orientation, mental disability, medical disability, age, marital status, family/parental status, or income.

KHS will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available.

In accordance with the Americans with Disabilities Act, KHS will ensure that deliverables developed and produced shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.
KHS will provide persons with disabilities who require alternative means of communication for program information to the appropriate alternate format to support their communication needs (e.g., Braille, large print, audiotape, American Sign Language, etc.)

KHS provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

A. Qualified sign language interpreters,
B. Information written in other languages,
C. Use of California Relay Services for hearing impaired.

**DEFINITIONS:**

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| Activities of Daily Living" or "ADL | ADL means activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation and transferring. |
| Community Based Adult Services (CBAS) | CBAS: An outpatient facility-based program that delivers skilled nursing care, social services, personal care, family/caregiver training and support, nutrition services and transportation to persons over the age of 18 years. CBAS is a Medi-Cal Managed Care benefit that provides core services to those that meet medical eligibility criteria. |
| Medical Eligibility Criteria | Medical Eligibility Criteria is based on medical necessity, as established by the State, and must be assessed through a face-to-face assessment and must meet one of five categories of the eligibility determination criteria on the CBAS eligibility determination tool (CEDT). |
| Chronic Mental Disorder | Chronic mental disorder means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:<br>A. Pervasive Developmental Disorders,<br>B. Attention Deficit and Disruptive Behavior Disorders,<br>C. Feeding and Eating Disorder of Infancy, Childhood, or Adolescence,<br>D. Elimination Disorders,<br>E. Schizophrenia and Other Psychiatric Disorders,<br>F. Mood Disorders,<br>G. Anxiety Disorders,<br>H. Somatoform Disorders,<br>I. Factitious Disorders,<br>J. Dissociative Disorders,<br>K. Paraphilia,<br>L. Eating Disorders, |

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| | M. Impulse Control Disorders Not Elsewhere Classified<br>N. Adjustment Disorders,<br>O. Personality Disorders, or<br>P. Medication-Induced Movement Disorders. |
| Categories of Medical criteria for eligibility | The member must also meet the following criteria:<br>A. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations, OR<br>B. Have a diagnosed organic, acquired, or traumatic brain injury, and/or chronic mental disorder.<br>1. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:<br>a. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or<br>2. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; or<br>C. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6,<br>D. Have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene.<br>E. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations. |
| CBAS Eligibility Determination Tool CEDT | CBAS Eligibility Determination Tool The purpose of the CBAS Eligibility Determination Tool is to incrementally document and support the final outcome of the eligibility determination process |
| Individual Plan of Care IPC | The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request. |
| Care Coordination | Care Coordination means the process of obtaining information from, or providing information to, the participating member, the member's family, the member's primary health care provider or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team. |
| Person-Centered Planning | Person- Centered Planning includes consideration of the current and unique bio psycho-social- cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. |

**PROCEDURES:**

**Referral and CBAS Eligibility Determination:**

A. Timeline for eligibility determination: KHS shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than thirty (30) calendar days from the initial eligibility inquiry request.

B. Individuals that may be eligible for CBAS with KHS must already be KHS members.

C. A request for initiation of CBAS services may come from one of the following sources:
    1. Community Based Adult Services Center
    2. Physician, physician assistant, nurse practitioner or other health care provider within scope of practice
    3. Nursing Facility
    4. Hospital
    5. Individual member
    6. Family member
    7. Community Based Organization
    8. KHS Case Management, Care Coordination, Social Services staff.

D. The inquiry may be done verbally or in writing.

E. The following information should be included at the time of the request:
    1. Member's Name
    2. Identification Number
    3. Date of Birth d. Contact Information of member, caregiver and referring agent. (Name, address, phone number)
    4. Reason the member needs CBAS services.

F. KHS reviews the referral and applies CBAS pre-screen criteria:
    1. Medi-Cal eligible
    2. 18 years old
    3. Medi-Cal coverage is assigned to KHS.

G. If the member does not meet pre-screening criteria, KHS will notify the requesting party and the member of ineligible status by mail within 5 business days.

H. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience using the DHCS CEDT Tool. (Attachment A).

I. An initial face-to-face review is not required when a KHS determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information obtained by KHS possesses, such as through prior-authorization, institutional concurrent review, or Case management.

J. KHS has contracted with licensed home health agency vendors to provide the RN accessor.

K. KHS ensures that the agency and RN accessors have been trained on CBAS protocols and the use of the CEDT Tool Instructions for Completing a CEDT Forms Instructions for Completing a CEDT Form.

L. KHS notifies Home Health Agency

M. RN assessor acknowledges, in writing, to requestor and member, the inquiry and makes first attempt to schedule F2F within 5 calendar days.
    1. The RN assessor makes two additional attempts via telephone to schedule between 5 and 8 calendar days of request.
    2. RN assessor makes final attempt in writing giving the member until day 14 to schedule F2F.
    3. If the member does not schedule within 14 days from inquiry, RN assessor will send a follow-up letter to member and the requestor that if services are still needed a new inquiry must be submitted to begin the process again.
    4. RN assessor conducts F2F with member using the following guidelines:
        a. CEDT Assessor must schedule F2F within 14 days.
        b. F2F must be completed, using CEDT tool, within thirty (30) days from initial inquiry.

N. Documentation for the F2F cannot include documents written by the CBAS center staff.

O. Documentation for the F2F includes documents provided by the member's medical, mental health and social services providers.

P. The KHS Approval or denial of eligibility for CBAS to conduct IPC will be sent to the Center within 1 business day of decision.

Q. Any decision for a denial will be made by the KHS Medical Director, or physician designee. A denial of CBAS eligibility based on the outcome of the F2F and CEDT will result in a NOA from the plan and the grievance and appeal rights apply.

R. A denial of CBAS eligibility based on the outcome of the F2F and CEDT will result in a NOA from the plan and the grievance and appeal rights apply.

S. The member has the right to choose a center if the requesting provider is not a CBAS center and if it is within the selected facility's time and distance criteria for transportation.

**CBAS Center IPC Initial Assessment and Authorization Requests**

A. Upon KHS notification and receipt of the CEDT from the RN assessor the CBAS Center receives authorization from KHS to conduct 3-day IPC assessment and a copy of the completed CEDT is sent to CBAS center.

B. The CBAS center multi-disciplinary team performs the 3-day assessment.

C. Once the assessment is completed the CBAS submits a prior authorization request, including IPC with Level of Service recommendation to the KHS UM Team.
    1. The completed IPC will indicate Level of Service recommendation.

D. The prior authorization service request will be reviewed by a UM Department RN, and either be approved, modified, or denied within 5 business days, in accordance with Health and Safety Code 1367.01 7

E. If the RN recommends based on criteria a denial recommendation the KHS Medical Director or physician designee, will review and make the determination for the denial.

F. If KHS cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and the center immediately in writing of the extension and what additional information is required to complete the review

G. If a denial is determined, KHS will issue the NOA denial.
    1. KHS will utilize DHCS-developed, standardized NOA templates (denial, delay, modification, termination) and corresponding "Your Rights" attachments to comply with new federal regulations.
    2. The Notice of Action letters together with the indicated enclosures contain all of the required elements for both provider and member notice of delay, denial, termination, modification, Carve Out, including the following:
        a. The date of the NOA,
        b. The action taken,
        c. A clear and concise explanation of the reason for the decision (including clinical reasons for decisions regarding medical necessity,
        d. A description of the criteria/guidelines used,
        e. A citation of the specific regulations or plan authorization procedures supporting the action
        f. Name and telephone number of the Chief Medical Officer, or their designee
        g. Information on how to file a grievance or appeal with KHS including the Plan's name address and phone number,
        h. The NOA must be written at 6$^{th}$ grade literacy for beneficiary understanding.
        i. KHS currently translates all grievance resolution and appeal NARs, including the clinical rationale for the decision, into the member's threshold language before mailing. Members with visual impairment may also receive their grievance and appeal correspondence in the alternative format of their choice, including Braille, audio cd or data cd.
    3. Refer to KHS UM P&P 3.22 P Titled "Referral and Authorization Process Determinations & Processing" for a comprehensive detailed description of NOA processing in compliance with DHCS APL-17-006 and APL-21-011.

H. For CBAS determinations KHS will notify the CBAS Center within 24 hours of the decision and will notify the members within two (2) business days.

**Expedited CBAS Inquiries**

A. The following circumstances fall under expedited:
    1. When a member is in a hospital or skilled nursing facility (SNF) whose discharge indicates the need for CBAS services.
    2. A member who is at high risk of admission to a hospital or SNF or,
    3. A member faces an imminent or serious threat to their health.

B. When a nursing facility or hospital identifies a potential need for expedited CBAS services in the discharge plan, or the member is residing in the community and is at risk for admission or imminent serious health threat and an inquiry is submitted or KHS staff through UM or case management processes identifies the need this will trigger the need to begin the CBAS face-to-face assessment under expedited criteria.

C. The expedited process will be conducted within 72 hours of a CBAS authorization request or identification of the needed service.

D. The Home Health Agency will schedule a face-to-face assessment at the nursing facility or hospital with the member and the facility as soon as possible from when the inquiry is received.

E. KHS shall arrange to conduct the face-to-face assessment with the member using the following parameters:

    1. The CEDT Assessor will schedule and complete the face-to-face assessment using the CEDT tool.

F. The approval or denial of eligibility will be sent to the CBAS provider within one (1)business day of the decision and will notify the member within two (2) business days.

    1. For approvals the CBAS provider will be instructed to develop an IPC.

**Individual Plan of Care (IPC)**

A. The Individual Plan of Care (IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law)

B. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

C. The planning process and the development and review of the IPC will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying:
    1. How the IPC will identify each member's preferences, choices and abilities and the strategies to address those preferences, choices, and abilities,
    2. How the IPC will allow the member to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing,
    3. How the IPC will ensure that the member has informed choices about treatment and

service decisions; and

4. How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

D. The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the Department of Health Care Services.

E. Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports.

F. KHS will ensure that members' ICPs are consistent with the individual member's overall care plans and goals.

G. Person- Centered Planning includes consideration of the current and unique bio, psycho-social, cultural, and medical needs, and history of the individual, as well as the person's functional level, support systems, and continuum of care needs with CBAS services serving as a part of the process.

H. The CBAS center staff, the member, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits.

I. Such review and updates must include an evaluation of progress toward treatment goals and objectives and reflect changes in the member's status or needs.

J. The IPC shall include at a minimum:
    1. Medical diagnoses
    2. Prescribed medications.
    3. Scheduled days at the CBAS center.
    4. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
        a. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).
        b. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
        c. Participation in specific group activities.
        d. Transportation needs provided or arranged, to and from CBAS participants' place of residence and the CBAS center, when needed, including special transportation.
        e. Special diet requirements, dietary counseling, and education, if needed
        f. A plan for any other necessary services that the CBAS center will coordinate.
        g. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team.
    5. Such review must include a review of the participant's progress, goals, and

objectives, as well as the IPC itself.

**CBAS Reassessments**

A. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

B. The reassessment will include family involvement as appropriate.

C. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, KHS may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider.

D. If a KHS member has an expiring TAR, the CBAS Center is to submit a service authorization request form with an updated Individual Plan of Care (IPC) and with the IPC and Level of Service Recommendation.

E. The service request will be reviewed by a UM RN.

F. The prior authorization service request will be reviewed by a UM RN, and either be approved, modified, or denied within five (5) business days, in accordance with Health and Safety Code 1367.01.

G. If the RN recommends based on criteria a denial recommendation the KHS Medical Director or physician designee, will review and make the determination for the denial.

H. If KHS cannot make a decision within five (5) business days a 14-day delay letter will be sent to the member and the center immediately in writing of the extension and what additional information is required to complete the review.

I. If a denial is determined, KHS will issue the Notice of Action denial.
    1. The NOA letter will include appeal rights and responsibilities.

J. KHS will notify the CBAS Center within one business day of the decision and will notify the members within 2 business days.

K. To deny or decrease the level of service, an F2F with the members shall be conducted.

L. If the level of service request remains the same, the RN reviewer may request more information if the IPC does not provide enough current information.

M. Additional information requests may include a summary of the client's current condition.

N. If an increase in the level of service is requested, KHS will arrange for an F2F to be conducted if sufficient information is not provided.
    1. Sufficient information includes updated IPC, summary of change in client, and

updates in the treatment plan. d. Any other supporting documents may be included (attach to IPC).

O. The CBAS center should not begin providing the increased level of service until after receiving KHS authorization approval.

P. KHS receives the service authorization request form with the number of authorized days.
    1. KHS reviews the new total of days requested on the form.
    2. KHS issues an approval or NOA letter, with the decision and includes a copy of the authorization form.
    3. If there is a decrease in the number of days, the KHS will notify the CBAS Center within 24 hours and will then send a NOA modification letter to the member within two (2) days.

**Unbundled Services**

A. In the event that CBAS services are no longer available or reach capacity in a given location, KHS Shall arrange CBAS-like services(unbundled) to those members that meet the eligibility criteria.

B. The CBAS RN will provide care coordination (person-centered planning) to ensure continuity of care.

C. The care coordinator will facilitate an assessment of the member to establish the member's needs. CBAS-like or Unbundled services are limited to:
    1. Professional Nursing Services,
    2. Personal Care Services,
    3. Social Services,
    4. Physical Therapy/Occupational Therapy (PT/OT) Maintenance Therapy
    5. Nutrition,
    6. Physical Therapy/Occupational Therapy/Speech Therapy (PT/OT/ST),
    7. Mental Health Services, and
    8. Transportation that meets non-emergency medical transportation (NEMT) guidelines.

D. KHS will assist the member in receiving unbundled CBAS component services based on the assessed needs through care coordination,

E. KHS will arrange for intermittent professional nursing services and PT/OT/ST needs that meet criteria for coverage under the Medi-Cal benefit.
    1. Referrals for such services may be made to appropriate providers for those members who have Medicare as their primary coverage.

F. KHS will make referrals to In-Home Supportive Services for consideration of additional personal care services that may include maintenance therapies.

G. KHS will make referrals to community agencies and services, such as Meals on Wheels, Senior Centers, Dial-A-Ride, etc. as needed.

**Defining Core Services**

The following are examples of each of the core services:

A. One or more of the following (5) professional nursing services:
    1. 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.
    2. Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications and interventions, as needed.
    3. 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.
    4. Supervision of the provision of personal care services for the participants and assistance, as needed.
    5. Provision of skilled nursing care and intervention, within scope of practice to participant, as needed.

B. One or both of the following personal care services:
    1. Protective group supervision and interventions to assure participant's safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.
    2. Supervision of, or assistance with activities of daily living or instrumental activities of daily living.

C. One or more of the following social services provided by the social worker or social worker assistant:
    1. Observation, assessment, and monitoring of the participant's psychosocial status
    2. Group work to address psychosocial issues.
    3. Care coordination

D. At least one of the following therapeutic activities provided by the CBAS Center activity coordinator or other trained personnel:
    1. Group or individual activities to enhance the social interaction, encourage physical exercise, or improve cognitive functioning of the participant to prevent deterioration.
    2. Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.

E. One meal per day of attendance, unless the participant declines, or medical contraindications exist.

**CBAS Emergency Remote Services**

A. In Accordance with DHCS All Plan Letter 22-020 in the event of a public emergency or a CBAS participant’s personal emergency, provisions are in place to prevent disruption of

services to include the inclusion of remote service delivery to CBAS participants by CBAS providers.

1. 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.
2. 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:
    a. "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. CBAS providers make the initial assessment regarding whether their participant has both experienced an emergency as defined in ERS policy AND per STC22, "assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting."
    b. "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.
    c. "Care Transitions" means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. If a CBAS participant is hospitalized or admitted to a SNF, the participant would not be attending the CBAS center for services or eligible for ERS. ERS may be appropriate as the participant transitions home and, once home, has need for remote CBAS support and services appropriate and feasible at that time. ERS provided during care transitions should address service gaps and Member/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

B. The CalAIM 1115 Waiver, authorized by the Centers for Medicare and Medicaid Services (CMS) in January 2022, included the provision of CBAS ERS as a component of the CBAS benefit, available to CBAS participants as needed, under unique circumstances when ERS policy criteria are met.

C. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings such as the community, in or at the doorstep of the participant's home, or via telehealth to allow for immediate response to address the continuity of care needs of CBAS participants when an emergency restricts or prevents them from receiving services at their center.

D. Effective October 1, 2022, CBAS ERS will be implemented as one of the required services under the CBAS program that all CBAS providers must make available to CBAS participants when all ERS policy criteria are met.

E. 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.
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 KS shall coordinate on requests for authorization of ERS that exceed three consecutive months.
    a. The determination for further authorization will be based upon the individual's care plan and a review for a continued need for remote/telehealth delivery of CBAS services." These services will be reviewed as a concurrent review request in accordance with Health and Safety Code 1367.01. For any ERS services provided prior to CBAS Center notification the services will be reviewed upon the notification and if deemed necessary and in compliance with APL 20-020 provisions authorized as part of the request.
    b. In determining the initial need for and/or duration of ERS, KHS will make determinations for the need of extended services based on the following considerations:
        i. Medical necessity – meaning that services and support are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain.
        ii. Hospitalization – whether the Member has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center.
        iii. Restrictions set forth by the Member's primary/personal health care provider due to recent illness or injury.
        iv. Member's overall health condition.
        v. Extent to which other services or supports meet the Member's needs during the emergency.
        vi. Personal crises such as sudden loss of caregiver or housing that threaten the Member's health, safety, and welfare.

KHS and CBAS providers are to coordinate to ensure that service and support needs are met, and as indicated, the duration for provision of ERS. The list of considerations included here are to guide decisions regarding ERS. A Member's emergency alone does not warrant provision of ERS. The Member must experience a public or personal emergency and need the services and supports CBAS provides under ERS. Members may choose to cease receipt of ERS at any time.

F. Oversight of Contracted CBAS Providers

CBAS RN will collaborate with CBAS providers contacting them as the TAS ends 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. For Members who choose to discontinue their CBAS services, KHS is responsible for ensuring care coordination occurs for these Members to ensure their needs continue to be met Members who are discharged from the CBAS program involuntarily may file a grievance with their MCP

or request a state fair hearing or independent medical review.

KHS will meet with the CBAS Centers annually or as needed to ensure the CBAS Centers are meeting all state requirements.

KHS will generate a monthly report on the total number of members who are receiving CBAS services. This report will be shared between Population Health Management (PHM) and Utilization Management (UM). Any discrepancies will be addressed accordingly and communicated with the CBAS Centers, if needed.

In addition, quality and continuous monitoring will be conducted annually by using the CBAS audit tool.

1. Audit findings will be communicated to the CBAS Centers.
2. CBAS Quality Monitoring activities will be reported to the KHS Quality Improvement Committee on a quarterly basis.
3. CBAS Centers will develop corrective action plans, if needed.
4. KHS will provide support and assistance to ensure findings are corrected.

**CBAS Transfers from Another CBAS Center**

A. A member who recently attended or is currently attending one of the CBAS centers may decide to attend another CBAS center.

B. If the member requests to switch to another center and it is still within the member's current authorization period or within 3 months after the member's latest CBAS authorization has expired, another CDET face-to-face is not required.

C. The center the member is transferring to must submit a copy of the client's latest authorization letter, a new authorization request, with level of service request, and a new IPC to KHS.

D. The CBAS Center is to select "Transfer from CBAS center" on the Service Request Form

E. The UM RN will review the request and verify the authorization for CBAS, and either be approved, modified, or denied within 5 business days, in accordance with Health and Safety Code 1367.01. The NOA will be sent to the CBAS provider within 24 hours of the decision and will notify the members within 2 business days.

F. If the member has stopped attending CBAS and the member's latest TAR has expired more than 3 months, a new CEDT F2F is required, and the initial assessment must be initiated. The center the member is leaving must send the discharge plan.

**Coordination with CBAS Providers**

KHS shall Coordinate member care with CBAS providers to ensure the following:

A. CBAS IPCs are consistent with members' overall care plans and goals developed by KHS.
B. Exchange of participant discharge plan information reports of incidents that threaten the welfare, health, and safety of the participant, and significant changes in participant condition

are conducted in a timely manner and facilitate care coordination.

C. The KHS CBAS RN is the main department contact for high acuity circumstances impacting members.

D. KHS through the development of policies and procedures both internally and in conjunction with CBAS policies and in conformance with regulatory provisions and the Medi-Cal Provider manual Part 2 CBAS Services gives guidance in designating responsibility for member eligibility determination, authorization, care planning, and utilization management.
    1. KHS will provide training education and written notification of KHS policy and procedure changes, education and training for providers will also be conducted during new provider onboarding, via provider manual and annual refreshers regarding any substantive changes that may have occurred.

E. KHS will encourage contracted CBAS providers to access educational and training materials provided by the CDA https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/

**Discharge Plan Requirements**

A. CBAS Centers are responsible for the discharge of participants with adequate planning for the member to safely transition to another arrangement.

B. CBAS Center participant discharge responsibilities include:
    1. Conducting ongoing discharge planning based on the assessment of the participant by the Center's multidisciplinary team in accordance with Title 22, California Code of Regulations (CCR), §54213, §78345, and §78437, and as prescribed in the Center's policy and procedures for discharge.
    2. Developing participant discharge plans that meet the requirements of Title 22, CCR, §78345, and contain the following per the California Bridge to Reform 1115 Demonstration waiver Special Terms and Conditions, to include:
        a. The date CBAS services are to end.
        b. The name of the member's physician(s)
        c. The name and contact number of the member's case manager (KHS)
        d. Specific information about the participant's current medical condition, treatments, and medication regimen
        e. Any referrals, medically necessary services or community resources the member may require after discharge,
        f. The signature of the beneficiary or representative and the date signed on the discharge Plan of Care.
        g. Provide a reason on the form for the discharge from the following list.
            i. Death
            ii. Long-term nursing facility placement
            iii. Other services obtained (e.g., care in the home, assisted living, etc.,)
            iv. Participant moves
            v. Voluntary discharge
            vi. Transferred to another CBAS center
            vii. Other

C. The discharge summary will be submitted using CDA 4008i CBAS Discharge Summary (Attachment C)

D. Upon discharge from the center, provide copies of the participant discharge plan to:
    1. The participant
    2. KHS

E. If a member is determined ineligible and denied CBAS services, KHS Care/Case Management teams will coordinate services as part of Enhanced Case Management (ECM). ECM services consist of Complex Case Management and Person-Centered Planning services including the coordination of eligible Medi-Cal beneficiaries' individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the Member and/or the Member's designees.

**Quality and Continuous Monitoring**

A. KHS will conduct planned and systematic monitoring of CBAS Centers to ensure overall quality assurance of CBAS services provided to KHS members.

B. CBAS Quality Monitoring activities will be reported to the KHS Quality Improvement Committee on a quarterly basis.

C. Quality and Continuous Monitoring will include the following activities:
    1. The CBAS RN shall develop a CBAS audit tool and conduct annual CBAS medical record audits to ensure CBAS centers are documenting services according to the Member's care plan.
    2. The CBAS Department shall monitor deficiencies identified by the California Department of Aging (CDA) certification initial and renewal survey Site Reviews.
        a. The UM Department shall monitor the weekly notices from the CDA for CBAS center closures, certification/renewal letters, citations, plans of correction/statements of deficiencies.
        b. The CDA is responsible for the screening and enrollment of the CBAS centers.
    3. Provider Relations is responsible for ensuring that all CBAS providers are screened and enrolled in the Medi-Cal program and verifying their credentials.
    4. The CBAS RN shall review a random sample of health records of eligible KHS CBAS participants on an annual basis.
        a. The files shall be audited for
            i. Adherence to the care plan
            ii. Documentation of services provided,
            iii. Current Individualized Plan of Care (IPC) including periodic revisions, comprehensive and periodic assessments.
        b. Follow-up of authorizations and activities,
        c. Compliant submission of the discharge Plan.
    5. Findings will be submitted to the KHS QIC to identify actions for any deficiencies.
        a. The CBAS center will be required for any deficiencies to do a Corrective Action Plan (CAP).
        b. The QIC will conduct as appropriate Potential Quality Issue (PQI) investigation.

6. The CBAS Centers are required to submit an incident Reporting form (ADHC/CBAS INCIDENT REPORT CDA 4009 (REV 10/2020) Attachment D to the QI Department within twenty-four (24) hours of the findings, along with supporting documentation of the reportable incident.
7. KHS will monitor member complaints and grievances to identify any adverse quality issues and or trends related to CBAS Center Providers and Services such as:
    a. KHS will monitor complaints and grievances related to access issues such as excessive drive/ride times to unable to access a CBAS provider of the member's preference.
    b. KHS will monitor appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested,
8. The KHS Compliance Department will monitor CBAS Center HIPAA Compliance to include the CBAS Centers telehealth delivery of service will meet HIPAA requirements and the methodology is accepted by the HIPAA compliance officer.

**HCBS Electronic Visit Verification System.**

A. For any in-home services provided to CBAS beneficiaries under the CBAS Emergency Remote Services, the state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by and home health services in accordance with section 12006 of the 21st Century CURES Act.
B. KHS providers providing Medi-Cal services to include CBAS service subject to EVV specifications shall comply with EVV requirements as determined by Federal and State Mandates as applicable to the Medi-Cal Program.
C. KHS CBAS Providers shall register with the state sponsored EVV system, Sandata Technologies, LLC portal registration at: https//vendorregistration.calevv.com
D. KHS providers of applicable CBAS services requiring EVV shall comply with the training requirements for EVV.
E. KHS will require in accordance with DHCS APL-22-014 billing and claims specifications as follows:
F. All applicable claims for CBAS services must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System codes as outlined in the Medi-Cal Provider Manual. MCPs and/or providers must also indicate the proper Place of Service Code or Revenue Code on claims and/or encounters to indicate the rendering of CBAS services in a member's home.
G. KHS will monitor providers for compliance with the applicable Electronic Visit Verification (EVV) requirements directed in CalEVV Information Notice(s) and DHCS APL notices.

**Reporting**

The following reports will be submitted to DHCS thirty (30) calendar days following the end of the reporting quarterly:

A. Number of Members who have been assessed for CBAS, and the total number of Members currently being provided with CBAS, both as a bundled or unbundled service.

B. Call Center Reports, including a review of any complaints surrounding the provision of CBAS benefits.
C. Grievance Log and Grievance Quarterly Reports, including reports on the following areas:
    1. Appeals related to requesting CBAS and inability to receive those services or receiving more limited services than requested.
    2. Appeals related to requesting a particular CBAS Provider and inability to access that provider.
    3. Excessive travel times to access CBAS services.
    4. Grievances regarding CBAS Providers
    5. Grievances regarding Contractor assessment and/or reassessment.

**DHCS In-Home Operations Unit Waiver Programs**

Waiver programs authorized under §1915(c) of the Social Security Act and administered by the DHCS In-Home Operations (IHO) Unit include the In-Home Medical Care Waiver and the Nursing Facility /Acute Hospital (NF/AH) Waiver found at hhtp://dhcs.ca.gov/services/Pages/IHO.aspx. Member referrals for these programs shall be submitted to the IHO Unit at the following address:

Department of Health Care Services
In-Home Operations Unit
Southern Region
311 South Spring St. 3rd Floor
Los Angeles, CA 90013

Provision of IHO Unit Waiver Program services is dependent upon concurrence of the beneficiary, guardian or authorized representative, primary care physician, and a licensed and certified home health agency. IHO requires each party to sign a letter of agreement to ensure that all Waiver participants understand their roles and responsibilities, as well as the benefits and limitations of the Waiver.

Once the County Welfare Department has determined that an individual is eligible for Medi-Cal in the home setting, the DHCSC In-Home Operations Unit staff will assess the beneficiary's medical condition to determine whether the individual would be appropriate for Waiver Services and which IHO Unit waiver program would be most appropriate.

[1] Placement in an IHO Unit administered waiver program will be determined if the agency administering the DHCS waiver program concurs with the Health Plan assessment of the member and if there is available placement in the waiver program, the Health Plan will initiate disenrollment for the member. The Health Plan will provide documentation to ensure the member's orderly transfer to the Medi-Cal Fee-For-Service program. The Health Plan will continue to cover and ensure that all Medically Necessary services are provided to members who must disenroll and receive services through the Medi-Cal Fee-for-Service program until the date of disenrollment is effective. If the member does not meet the criteria for the waiver program, or if placement is not available, the Health Plan will continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the member.

**DHCS**

If required for participation in the waiver program, the Health Plan shall initiate disenrollment upon the member's acceptance into a Waiver Program.

**HIV/AIDS Waiver Program[2]**

The office of AIDS administers the HIV/AIDS Home and Community Based Services Waiver Program. Placement in the Waiver Program does not require disenrollment from the Health Plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the Waiver Program and enrollment is dependent on available space.

## ATTACHMENTS

- Attachment A: CBAS Eligibility Determination Tool -CEDT
- Attachment B: Individual Plan Care Form
- Attachment C: CDA 4008i CBAS Discharge Summary
- Attachment D: CDA 4009 Incident Report

## REFERENCE:

**Revisions 2023-06:** Policy was renumbered to UM Dept, it was previously 19.21-I. **Revision 2023-05:** Revised for DHCS APL 23-004, SNF-LTC Benefit Standardization & Transition of Members. DHCS Approval received on 5/22/2023. Policy submitted to comply with 2024 OR, artifacts R.0218, approval received on 6/15/2023 and R.0219, approval received on 6//2023. **Revision 2022-12:** Policy submitted to comply with 2024 OR, artifacts R.0215, approval received on 12/7/2023, and R.0216, approval received on 1/27/2023. R.016 included additional references #4 and 5 listed below. **Revision 2022-11:** For DHCS APL 22-020, CBAS ERS. AIR #1 received on 2/6/23 resulting in policy revisions. DHCS approved policy on 2/16/23.


1. Social Security Act, Section 1915(c)
2. CA DHCS & CA Department of Aging Bridge to Reform 1115 Waiver Amendment Community-Based Adult Services Providers Standards of Participation https://www.kff.org/wp-content/uploads/sites/3/2013/12/cbassopsfinal2012-28-11.pdf
3. California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs), including Sections VIII.A.19 through 30 and Attachments H and S
4. Exhibit A Attachment III Section 5.2.8.J Community Based Adult Services
5. Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) Section VII.A.51.b.
6. California Department of Aging (CDA) CBAS Bureau ACL 22-04 https://aging.ca.gov/download.ashx?lE0rcNUV0zat4VbuY0SwBw%3d%3d
7. DHCS Medi-Cal Provider Manal Part 2 - Community–Based Adult Services https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*o00*+OR+*_*o01*+OR+*_*z00*+OR+*_*z02*&wFLogo=Part2+%23+Community%e2%80%93Based+Adult+Services&wPath=N
8. DHCS APL 22-014
9. DHCS APL 22-020
10. CA Health and Safety Code Health and Safety Code 1367.01
11. DHCS Kern Health Systems 22-20201 Exhibit A SOW, 4.3.21 HCBS Waiver Programs A, B
12. KHS Utilization Management Program
13. Title 22, California Code of Regulations (CCR), §54213, §78345, and §78437,


[1] DHCS Contract A-11 (17)(C)
[2] DHCS Contract A-11 (13)

Department of Health Care Services

# California Dept. of Health Care Services - Community Based Adult Services (CBAS)
# -- CBAS Eligibility Determination Tool (CEDT) --

**Part 1**

NAME: _____ SEX: ☐ M ☐ F CIN: _____

BIRTHDATE: _____ AGE: _____ PREFERRED LANGUAGE: _____

CAREGIVER: _____ CONTACT #: _____

CBAS REQUESTED BY: _____ DATE: _____

DATE ASSESSED: _____ INTERVIEW (F2F) LOCATION: _____

## A. DIAGNOSES / CONDITIONS *(Capture Source for each Diagnosis – e.g., MR,F2F,CG)*

| | | | |
|---|---|---|---|
| 1. | 4. | 7. | 10. |
| 2. | 5. | 8. | 11. |
| 3. | 6. | 9. | 12. |

## B. MEDICATIONS *(Capture Source for each Medication – e.g., MR,F2F,CG) (Capture all Meds including OTC Meds)*

| | | | |
|---|---|---|---|
| 1. | 6. | 11. | 16. |
| 2. | 7. | 12. | 17. |
| 3. | 8. | 13. | 18. |
| 4. | 9. | 14. | 19. |
| 5. | 10. | 15. | 20. |

## C. ASSISTIVE/SENSORY DEVICES

☐ Dentures _____ ☐ Vision _____ ☐ Hearing _____ ☐ Prosthesis _____

**Explain**: *(Capture Source of Information – e.g., MR,F2F,CG)*

## D. SYSTEMS REVIEW

**1. NEUROLOGICAL** ☐ Within normal limits

☐ Expressively Aphasic – Unable to express basic needs
☐ Receptively Aphasic – Unable to understand basic communication
☐ Pain: _____
☐ Other: _____
☐ Seizures
☐ Spasticity
☐ Compromised Motor Function

**Explain** *(Capture Source of Information – e.g., MR,F2F,CG)*

## 2. RESPIRATORY / CARDIAC ☐ Within normal limits

☐ Oxygen - ☐ Continuous ☐ Intermittent
☐ Tracheostomy
☐ Ventilator ☐ BiPAP ☐ CPAP ☐ Nebulizer
☐ SOB ☐ Edema
☐ Pain: _____

☐ Pacemaker/Defibrillator
☐ BP/Pulse Monitor - ☐ Self ☐ Caregiver
Frequency: _____
☐ Other: _____

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

## 3. GASTROINTESTINAL / GENITOURINARY

☐ Regular Diet ☐ Special Diet: _____
☐ Feeding Tube - ☐ NG Tube ☐ PEG Tube
☐ IV Feedings ☐ Dysphagia
☐ Requires modified food/liquid consistency
☐ Overweight ☐ Underweight
☐ Pain: _____
☐ Other: _____

Bladder ☐ Normal
☐ Bladder incontinence
☐ Indwelling Foley catheter
☐ Suprapubic catheter
Bowel ☐ Normal
☐ Bowel incontinence
☐ Ostomy

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

## 4. ENDOCRINE ☐ Within normal limits

☐ Diabetes Mellitus
☐ Diet Controlled
☐ Oral medication
☐ Insulin Injections
☐ Sliding Scale Coverage

☐ Blood Glucose Monitoring - ☐ Self ☐ Caregiver
Frequency: _____

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

## 5. INTEGUMENTARY ☐ Within normal limits; skin is intact

☐ Previous skin problems
☐ Pain: _____

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

Describe current skin lesions, stasis ulcers, wounds, bruising, or other skin integrity issues.

| Location: | Description: (include, size, healing status) | Wound Care/Treatment: (include frequency) |
|---|---|---|
| | | |

## 6. MUSCULO-SKELETAL ☐ Within normal limits

☐ Ambulatory
☐ Independent ☐ Cane ☐ Walker ☐ Orthotics
☐ Wheelchair ☐ Able to self-propel wheelchair
☐ Scooter
☐ Bed Bound
☐ Transfer Needs

☐ Weakness ☐ Contractures
☐ Limited range of motion ☐ Joint replacement
☐ Paralysis
☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia
☐ History of falls in last 6 months ☐ Poor Balance
☐ Pain: _____
☐ Other: _____

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

## 7. COGNITIVE & BEHAVIORAL FACTORS ☐ Within normal limits

Dementia Stage: _____
☐ Cognitive Loss ☐ Memory Loss
☐ Confused ☐ Limited Response
☐ Poor Judgment

☐ Isolated ☐ Self-neglect ☐ Wandering
☐ Disruptive ☐ Agitated ☐ Aggressive
☐ Substance Abuse
☐ Other: _____

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

# E. MEDICATION MANAGEMENT ☐ Independent

☐ Medication management assistance needed - ☐ Human assistance ☐ Device assistance
☐ Hx of Non-Adherence
Reasons for non-adherence: ☐ Forgetfulness, Confusion, Cognitive Deficits ☐ Physical disability
☐ Cost, Health Beliefs, Side Effects ☐ Other Causes
☐ Central lines

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

## F. ADL/IADLs

**Independent:** Able to perform for self with or without device.
**Supervision:** No physical help req'd; needs cueing or to be monitored, even w/ device.
**Assistance:** Physical help required, even with device.
**Dependent:** Unable to do for self, even with physical help, cueing or device.

| ADLs | Independent? | Explain Responses & Identify Source |
|---|---|---|
| Ambulation | ☐ Y ☐ N | |
| Bathing | ☐ Y ☐ N | |
| Dressing | ☐ Y ☐ N | |
| Feeding | ☐ Y ☐ N | |
| Toileting | ☐ Y ☐ N | |
| Transferring | ☐ Y ☐ N | |
| **IADLs** | | |
| Hygiene | ☐ Y ☐ N | |
| Medication Mgmt | ☐ Y ☐ N | |
| **Additional IADL Exceptions:** | | |
| Transportation | ☐ Y ☐ N | |
| Access Resources | ☐ Y ☐ N | |
| Meal Preparation | ☐ Y ☐ N | |
| Money Mgmt | ☐ Y ☐ N | |

## G. ADDITIONAL SUPPORT INFORMATION

**Currently Receiving Other Non-CBAS Services/Waivers**

*NOTE: check boxes only if known and readily available during F2F and/or review of available and relevant documentation.*

☐ IHSS Services Received - Hrs/Month: _____
☐ In-Home Waiver
☐ Assisted Living Waiver
☐ Home/Community Based DD Waiver
☐ MSSP
☐ Other: _____
☐ Nursing Facility/Acute Hospital Waiver
☐ Specialty Mental Health Waiver Services
☐ Hospice Services
☐ Home Health Services
☐ Physical Therapy
☐ Meals on Wheels

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

**Recent Health Care Encounters**

**Within last 6 months** Unknown? ☐

☐ PCP Visit
☐ Clinic Visit
☐ Specialty Physician Visit
☐ Emergency Room Visit
☐ Inpatient Mental Health
☐ CBAS Center
☐ Hospitalization
☐ Nursing Facility

**Explain:** *(Capture Source of Information – e.g., MR,F2F,CG)*

# H. AE&MN QUALIFICATION CRITERIA

Part 2

| Category | Criteria |
|---|---|
| **Basic Qualifications**<br><br>☐ Y ☐ N Qualifies?<br>(requires Y for all of first five choices **OR** Y for sixth choice) | ☐ Y ☐ N The person is 18 years of age or older<br>☐ Y ☐ N The person has one or more chronic or post-acute medical, cognitive, or mental health conditions<br>List qualifying medical, cognitive, or mental health condition(s)<br>_____<br>_____<br>_____<br>☐ Y ☐ N A physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested CBAS services.<br>☐ Y ☐ N The person requires Ongoing or Intermittent Protective Supervision by a skilled health or mental health professional to improve, stabilize, maintain, OR minimize deterioration of the medical, cognitive, or mental health condition(s) listed above.<br>☐ Y ☐ N CBAS is required to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, nursing facility services, or nursing or intermediate care facility services for the developmentally disabled providing continuous nursing care.<br>**OR**<br>☐ Y ☐ N Participant resides in an ICF/DD-H and that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.<br>Explain: |
| **Other Chronic or Post-Acute Conditions**<br><br>☐ Y ☐ N Qualifies?<br>(requires Y for at least one choice) | The candidate has one or more medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:<br>☐ Y ☐ N Needs Monitoring, **OR** Treatment, **OR** Intervention<br>For Condition(s) _____<br>**OR**<br>☐ Y ☐ N Candidate resides in an ICF/DD-H<br>Explain: |
| **Living Situation**<br><br>☐ Y ☐ N Qualifies?<br>(requires Y for at least one of four choices) | The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:<br>☐ Y ☐ N Lives alone<br>To provide sufficient and necessary care or supervision:<br>☐ Y ☐ N Family or Caregivers not available<br>☐ Y ☐ N Participant resides with one or more individuals, but they are unwilling or unable<br>☐ Y ☐ N Family or caregivers available, but those individuals require respite in order to continue<br>Explain: |

**Deterioration Potential**

☐ Y ☐ N Qualifies?
(requires Y)

☐ Y ☐ N A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

Explain:

**CORE Professional Nursing Services**

☐ Y ☐ N Qualifies?
(requires Y for one or more of the five Core Professional Nursing Services listed)

### 1 - Health Status

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require:

☐ Y ☐ N Intermittent Observation, **AND** Assessment, **AND** Monitoring

For Condition(s) _____

Explain:

### 2 - Medication Regimen

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications, and intervention, as needed, based upon the assessment and the participant's reactions to his or her medications.

Explain:

### 3 - Oral or Written Communication

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Professional nursing services to communicate accurate information regarding changes in the participant's condition, signs, or symptoms to health care providers, social service provider, participant’s family, or caregiver.

Explain:

### 4 - Personal Care Service Supervision

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Supervision of the provision of personal care services, and assistance, as needed

Explain:

### 5 - Skilled Nursing Care and Intervention

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Skilled Nursing Care and Intervention to provide self-care while at a CBAS Center.

Explain:

| | |
|---|---|
| **CORE Personal Care / Social Services**<br><br>☐ Y ☐ N Qualifies?<br>(requires Y for one or more of the five services listed) | **Personal Care & Social Services**<br>To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require:<br>☐ Y ☐ N Supervision/assistance with ADL's/IADL's<br>☐ Y ☐ N Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering<br>☐ Y ☐ N Individual observation, assessment and monitoring of psychosocial issues on an intermittent basis<br>☐ Y ☐ N Group work to address psychosocial issues.<br>☐ Y ☐ N Care Coordination (e.g., medical appointments, transportation)<br>Explain: |
| **CORE Therapeutic Activities**<br>☐ Y ☐ N Qualifies?<br>(requires Y for one or more of the two services listed) | To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require:<br>☐ Y ☐ N Group or individual activities to enhance the social, physical or cognitive functioning of the candidate<br>☐ Y ☐ N Facilitated participation in group or individual activities because of frailty/cognitive functioning level that precludes them from active participation in scheduled activities<br>Explain: |

# I. CBAS ELIGIBILITY DETERMINATION – Eligibility Categories

Part 3

**The individual meets the following CBAS eligibility categories: (Check all that apply)**

## ☐ Category 1

☐ **Nursing Facility Level A (NF-A) or above**
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

## ☐ Category 2

☐ **Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness**
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).
☐ **AND** Demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs:

Bathing, dressing, self-feeding, toileting, ambulation, med. management, transferring, hygiene

**OR** 1 ADL/IADL listed above and 1 IADL from below:

Money management, accessing resources, meal preparation, transportation

Explain:

## ☐ Category 3

☐ **Alzheimer's disease or other dementia:** moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5, 6 or 7 Alzheimer's disease
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

## ☐ Category 4

☐ **Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias** characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).
☐ **AND** Demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs:

Bathing, dressing, self-feeding, toileting, ambulation, med. management, transferring, hygiene

Explain:

## ☐ Category 5

☐ **Individuals who have Developmental Disabilities** meeting the definitions and requirements set forth in title 17, section 54001(a) of the California Code of Regulations, as determined by a Regional Center under contract with the Department of Developmental Services.
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

## ☐ DOES NOT MEET eligibility criteria for CBAS – does not meet any of the eligibility Categories listed above.

Explain:

# J. SIGNATURES

**Face-to-Face Assessor Recommendation**

☐ **The individual <u>appears to meet</u> the criteria for Community Based Adult Services (CBAS)**

☐ **The individual <u>does not appear to meet</u> the eligibility criteria for CBAS.**

Assessor Signature/Credential:_____ Date: _____

## Health Plan / Field Office Review Section

**Optional Quality Review** ☐ **Not Applicable**

☐ Agree with Assessor ☐ Disagree with Assessor

Quality Reviewer Signature/Credential: _____ Date: _____

Comments:

**2nd Level Review** ☐ **Not Applicable**

☐ **The individual <u>meets</u> the criteria for Community Based Adult Services (CBAS)**

☐ **The individual <u>does not meet</u> the criteria for CBAS.**

2nd Level Reviewer Signature/Credential: _____ Date: _____

For existing CBAS participants that <u>do not meet</u> the criteria for CBAS, CBAS Center Program Director was notified on:

Date:_____ Time:_____

Comments:

# Comment Page

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
**INDIVIDUAL PLAN OF CARE**
DHCS 0020 (REV 07/2019)

COMMUNITY-BASED CBAS ADULT SERVICES

| **Center Name:** | **Provider # (NPI):** |
|---|---|
| Participant Name: | |
| Date of Birth (MM/DD/YY): | CIN: |
| Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female | |
| Managed Care Plan Name: | |
| Dates of Service: From: _____ To: _____ | Planned Days/Week (#_____) |
| TAR Control Number (TCN): | |

**(1) TREATMENT AUTHORIZATION REQUEST (TAR) AND ELIGIBILITY**

☐ Initial TAR ☐ Reauthorization TAR ☐ Change TAR

TB Clearance Date (initial TAR only): _____

If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were denied. ☐ Yes ☐ No ☐ N/A

☐ The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories as set forth in the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020:

- ☐ **Category 1**: Nursing Facility Level A (NF-A) or above
- ☐ **Category 2**: Organic, acquired or traumatic brain injury and/or chronic mental disorder
- ☐ **Category 3**: Alzheimer's disease or other dementias at moderate to severe level
- ☐ **Category 4**: Mild cognitive impairment including Alzheimer's disease or other dementias
- ☐ **Category 5**: Individuals who have developmental disabilities

**(2) DIAGNOSES AND ICD CODES**

| Diagnosis | ICD Code | Diagnosis | ICD Code |
|---|---|---|---|
| **1.** | | **2.** | |
| **3.** | | **4.** | |
| **5.** | | **6.** | |
| **7.** | | **8.** | |
| **9.** | | **10.** | |
| **11.** | | **12.** | |
| **13.** | | **14.** | |

COMMUNITY-BASED CBAS ADULT SERVICES

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| Diagnosis | ICD Code | Diagnosis | ICD Code |
|---|---|---|---|
| **15.** | | **16.** | |
| **17.** | | **18.** | |
| **19.** | | **20.** | |

**(3) MEDICATIONS**

☐ No medications or supplements

| ACTIVE PRESCRIPTIONS | | OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS |
|---|---|---|
| **1.** | **2.** | |
| **3.** | **4.** | |
| **5.** | **6.** | |
| **7.** | **8.** | **1.** |
| **9.** | **10.** | **2.** |
| **11.** | **12.** | **3.** |
| **13.** | **14.** | **4.** |
| **15.** | **16.** | **5.** |
| **17.** | **18.** | **6.** |
| **19.** | **20.** | **7.** |
| **21.** | **22.** | **8.** |
| **23.** | **24.** | **9.** |
| **25.** | **26.** | **10.** |

Center administers participant's prescribed medication(s) ☐ Yes ☐ No
Participant self-administers prescribed medication(s) at center ☐ Yes ☐ No

**(4) ACTIVE PERSONAL MEDICAL/MENTAL HEALTH CARE PROVIDER(S)**

| NAME | PROVIDER SPECIALTY | ADDRESS | PHONE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

COMMUNITY-BASED CBAS ADULT SERVICES

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

## (5) ADL/IADLs

**Independent:** able to perform for self with or without device

**Needs Supervision:** no physical help required but needs to be monitored, even with device

**Needs Assistance:** physical help or cueing required, even with device

**Dependent:** unable to do for self, even with physical help, cueing or device

| ADLs | INDEPENDENT | NEEDS SUPERVISION | NEEDS ASSISTANCE | DEPENDENT |
|---|---|---|---|---|
| Ambulation | ☐ | ☐ | ☐ | ☐ |
| Bathing | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ |
| Self-Feeding | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ |
| Transferring | ☐ | ☐ | ☐ | ☐ |

| IADLs | INDEPENDENT | NEEDS SUPERVISION | NEEDS ASSISTANCE | DEPENDENT |
|---|---|---|---|---|
| Accessing Resources | ☐ | ☐ | ☐ | ☐ |
| Hygiene | ☐ | ☐ | ☐ | ☐ |
| Meal Preparation | ☐ | ☐ | ☐ | ☐ |
| Medication Mgmt. | ☐ | ☐ | ☐ | ☐ |
| Money Mgmt. | ☐ | ☐ | ☐ | ☐ |
| Transportation | ☐ | ☐ | ☐ | ☐ |

## (6) CURRENT ASSISTIVE/ADAPTIVE DEVICES

☐ None

☐ Wheelchair ☐ Walker ☐ Gait Belt ☐ Crutches ☐ Hoyer Lift ☐ Cane

☐ Dentures ☐ Glasses or Other Vision Aids ☐ Orthosis/Prothesis

☐ Hearing Device ☐ Augmentative and Alternative Communication (AAC) Device

☐ Specialized Eating Equipment/Utensils

☐ Respiratory Equipment (specify): _____

☐ Other (specify): _____

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

## (7) CONTINENCE INFORMATION

☐ Continent

☐ Incontinent of bladder: ☐ Occasionally ☐ Frequently ☐ Always

☐ Incontinent of bowel: ☐ Occasionally ☐ Frequently ☐ Always

☐ External/internal catheter ☐ Ostomy

☐ Other (specify): _____

## (8) NUTRITIONAL INFORMATION

☐ Body Mass Index (BMI) _____ ☐ Underweight ☐ Normal ☐ Overweight ☐ Obese

☐ BMI Not Known ☐ Feeding tube ☐ Special/therapeutic diet (specify): _____

☐ Difficulty chewing and/or swallowing ☐ Needs dietary counseling and education

☐ Other (specify): _____

## (9) LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION AND NON-CBAS LONG TERM SUPPORT SERVICES (if known)

**LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION**

Type of Residence:

☐ Personal Residence (house/apartment)

☐ Community Care Licensed Facility (e.g., Residential Care Facility)

☐ Other Congregate Living

☐ ICF/DD-H ☐ Homeless/Temporary Shelter

☐ Other (specify): _____

Household Composition:

☐ Alone ☐ Relative (specify): _____ ☐ Non-relative (specify): _____

This space intentionally left blank.

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**SUPPORT SERVICES (IN ADDITION TO CBAS)**

☐ Not known ☐ None

☐ IHSS (In Home Supportive Services) (Number of Hours/Month: _____)

☐ Care Management Program: ☐ MSSP ☐ Regional Center

☐ Other (specify): _____

☐ Veterans Administration Services (specify): _____

☐ Home Delivered Meals ☐ Friendly Visitor/Senior Companion/Peer Counselor

☐ Telephone Reassurance ☐ Transportation

☐ Representative Payee ☐ Conservatorship ☐ Other (specify): _____

**(10) OTHER HEALTH SERVICES (if known)**

**WITHIN THE PAST 6 MONTHS**

☐ None

☐ Not Known

☐ Emergency Department Visit(s)

# visits: _____

Explain: _____

☐ Medical Hospitalization(s)

# times admitted: _____

Explain: _____

☐ Psychiatric Hospitalization(s)

# times admitted: _____

Explain: _____

☐ Nursing Facility

Explain: _____

☐ Home Health Services

☐ Currently receiving

Explain: _____

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

## OTHER HEALTH SERVICES (if known) Continued

**WITHIN THE PAST 6 MONTHS**

☐ Hospice Care

☐ Currently receiving

Explain: _____

☐ Mental Health Outpatient Services

☐ Currently receiving

Explain: _____

☐ Other (specify): _____

## (11) RISK FACTORS (check all that apply at time of IPC completion)

**INTERNAL/CLINICAL RISK FACTORS**

☐ None

☐ Mental Illness

☐ Substance Use/Abuse

☐ Cognitive Impairment

☐ Polypharmacy (6+)

☐ Medication Mismanagement

☐ ADL Functional Limitations (3+)

☐ High Fall Risk

☐ Chronic Pain

☐ Frailty

☐ Wandering/Exit-Seeking Behavior

☐ Significant Sensory Impairment

☐ Other (specify): _____

**EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH**

☐ None

☐ At Risk When Home Alone

☐ Limited or No Social Supports/Family

☐ Caregiver Stress/Inconsistency

☐ IHSS Inconsistency

☐ Social Isolation/Loneliness

☐ Emergency Department (ED) visit within 30 days

☐ Hospitalization (unplanned) within 60 days

☐ Unstable or Unsafe Housing

☐ Homeless/history of homelessness

☐ Financial Insecurity/Poverty/Lack of Resources

☐ Food Insecurity

☐ Lack of Transportation to Medical Visits

☐ Limited Health Literacy

☐ Language/Communication Barriers

☐ Other (specify): _____

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| **(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS** | |
|---|---|
| 1. | |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| 2. | |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| 3. | |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| 4. | |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| 5. | |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| **Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.** | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| **(13) CORE SERVICES** | | |
|---|---|---|
| **PROFESSIONAL NURSING SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
| 1. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**PROFESSIONAL NURSING SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 3. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |
| 4. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**PERSONAL CARE SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 1. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**SOCIAL SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 1. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**SOCIAL SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 3. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |
| 4. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**THERAPEUTIC ACTIVITIES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

1. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

2. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| **THERAPEUTIC ACTIVITIES – PHYSICAL THERAPY MAINTENANCE PROGRAM**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
|---|---|---|
| 1. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| **THERAPEUTIC ACTIVITIES – OCCUPATIONAL THERAPY MAINTENANCE PROGRAM**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
|---|---|---|
| 1. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

| **(14) ADDITIONAL SERVICES** | | |
|---|---|---|
| **PHYSICAL THERAPY**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
| 1. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**OCCUPATIONAL THERAPY**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

1. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

2. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**SPEECH THERAPY**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

1. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

2. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**REGISTERED DIETICIAN SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

1. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

2. Need/Problem

| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| | | |

COMMUNITY-BASED CBAS ADULT SERVICES

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**BEHAVIORAL HEALTH SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 1. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**TRANSPORTATION SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**

| 1. Need/Problem | | |
|---|---|---|
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |
| 2. Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| | | |

COMMUNITY-BASED CBAS ADULT SERVICES

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**(15) SIGNIFICANT CHANGES SINCE PREVIOUS IPC** (For reauthorization TARs only)

**(16) ADDITIONAL INFORMATION** (include critical history/information not included in this IPC and relevant to the authorization of this TAR)

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

## (17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR

**Signatures of the Multidisciplinary Team (MDT)**

Pursuant to section 14529 of the Welfare and Institutions Code, signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice.

| PRINTED NAME | SIGNATURE | DATE OF SIGNATURE |
|---|---|---|
| | RN | |
| | SW | |
| | AC | |
| | PT | |
| | OT | |
| | | |
| | | |
| | | |

By signing below I certify that I have reviewed and concur with this IPC.

| PRINTED NAME | SIGNATURE OF THE PRIMARY/PERSONAL HEALTH CARE PROVIDER OR CBAS CENTER PHYSICIAN | DATE OF SIGNATURE |
|---|---|---|
| ☐ Primary/Personal Health Care Provider | ☐ CBAS Center Physician | |
| | | |

By signing below, I certify the following: (1) all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in this IPC effective on this date: _____ (NOTE: The TAR will not be approved for CBAS services prior to this date); (2) information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records; and (3) services scheduled in this IPC will be provided, unless otherwise noted in the health record, after approval of the participant's CBAS eligibility and TAR, and after the participant or authorized representative has signed the CBAS Participation Agreement (Form CDA 7000), no later than the first day of enrollment, consenting to services.

| PRINTED NAME | SIGNATURE | DATE OF SIGNATURE |
|---|---|---|
| | Program Director | |

Privacy Statement: The information requested on this form is required by the Department of Health Care Services, Fee-for-Service or Managed Care Plans, for the purpose of adjudication of TARS for CBAS services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**Please use this page to document additional Box 13 and 14 services.**

| **_____ SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
|---|---|---|
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**Please use this page to document additional Box 13 and 14 services.**

| **_____ SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
|---|---|---|
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

COMMUNITY-BASED CBAS ADULT SERVICES

| Participant Name: | |
|---|---|
| Dates of Service: From: _____ To: _____ | CIN: |

**Please use this page to document additional Box 13 and 14 services.**

| **_____ SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____** | | |
|---|---|---|
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |
| Need/Problem | | |
| Treatment(s)/Intervention(s) | Frequency | Goal(s) |

# Instructions for Completing a CEDT Form

The CEDT is divided into three (3) parts:

**Part 1 (Demographics and Sections A to G)** – The *Assessment/Evaluation* part of the CEDT where the assessor captures relevant demographic information, systems review input, functional review input, and additional support information.

**Part 2 (Section H)** – The *AE&MN Qualification Criteria* section that uses information from Part 1 to evaluate compliance with the "ADHC Eligibility and Medical Necessity" (AE&MN) criteria that must be met to qualify for any of the five (5) CBAS eligibility categories in Part 3.

**Part 3 (Sections I & J)** – The *Eligibility Outcomes* part of the CEDT where the assessor uses information from Parts 1 and 2 to evaluate compliance with the component eligibility criteria for each of the five (5) CBAS eligibility categories. This part also includes a signature section (Section J) to record various review steps and roles in the determination process.

The purpose of the CBAS Eligibility Determination Tool is to incrementally document and support the final outcome of the eligibility determination process as captured on Part 3 of the CEDT Form. With this purpose in mind, please do the following:

## General Instructions

1. Plan each assessment with the end in mind:
   a. Look at the 5 categories of eligibility in Part 3 and their 2 or 3 component eligibility elements. This serves to imprint the qualifying diagnoses or conditions and ADL/IADLs so you are looking for them in Part 1 (during the candidate interview).
   b. Look at Part 2 to see the characteristics of the participants that need to be catalogued to illustrate compliance with the core ADHC Eligibility & Medical Necessity criteria. Nurses experienced in these assessments can have these in mind and catalog these elements in Part 1 of the CEDT during the candidate interview.
2. It is important to complete the entire form. Document the identified information in each section of the form, including areas labeled "Explain". Use the "Explain" areas to capture information relevant to the respective subsection of the form including information that may be unknown or unavailable.
3. If insufficiencies exist that may contribute to a denial of eligibility, please describe the insufficiency and the relevant source(s).
4. For the purposes of an independent determination of CBAS eligibility, Assessors are allowed to accept documentation from CBAS Providers that is not developed by CBAS Providers or staff affiliated with the CBAS Center (e.g., H&P documentation provided by an external primary care provider is acceptable).

## Part 1 Instructions – Assessment / Evaluation

5. Fill in the demographic information at the top of Page 1 following the labels provided. Include the name of the health care provider that requested CBAS for the candidate and the date of the request. This is important for compliance with AEMNC in Part 2.
6. Complete Sections A through C by entering identified Diagnoses / Conditions, Medications, and Assistive /Sensory Devices, providing brief explanations as the form allows.
7. Complete the "Systems Review" section (Section D), being sure to acknowledge each subsection (1-7) as within normal limits or by completing other status indicators that are provided.
8. Complete the "Medication Management" section (Section E), being sure to acknowledge that the candidate is either independent or is not independent as supported by other status indicators that are provided.
9. Complete the status assessment for the ADLs and IADLs listed in Section F and capture the source of information for each in the "Explain Responses & Identify Source" fields.
10. Complete Section G to characterize other non-CBAS services that are currently provided to the participant as well as recent health care encounters. This information can be helpful to completing Part 2 of the CEDT (Section H).

## Part 2 Instructions – AE&MN Qualification Criteria

11. Using information documented in Part 1 of the CEDT, complete Section H. Complete appropriate check boxes under the "Criteria" column for each Category listed.
12. Check the Yes/No check box for "Qualifies?" in each Category if the appropriate Criteria have been satisfied.
13. If each of the "Qualifies" check boxes are marked "Y" in Section H then all of the AEMNC have been satisfied. This is important to completing Part 3 of the CEDT (Section I).
14. For any Category that has not been checked as "Qualified", review the underlying Criteria and supportive information in Part 1 to be sure insufficiencies have been properly documented.

## Part 3 Instructions - Eligibility Outcomes

15. Using information documented in Part 1 and Part 2 of the CEDT, complete Section I. The check boxes under each "Category" (e.g., Category 1) reflect the 2 or 3 elements of eligibility that must be satisfied to meet the requirements for CBAS eligibility for the respective Category. Complete appropriate check boxes for the 2 or 3 elements of eligibility under each category as appropriate.
16. Check each eligibility Category whose 2 or 3 elements of eligibility are completely checked.
17. If the candidate does not qualify under any category, review the underlying information in Parts 1 and 2 and properly document insufficiencies that support the lack of eligibility of CBAS.
18. If the candidate does not qualify under any category, check the box for "DOES NOT MEET eligibility criteria for CBAS".
19. Upon completion of Section I, move to Section J and complete the box labeled "Face-to-Face Assessor Recommendation".
    a. If the *Optional Quality Review* is "Not Applicable" and the *2nd Level Review* is "Not Applicable" then check the respective "Not Applicable" boxes in those signature areas. The Face to Face Assessor Recommendation is then considered the final outcome.
    NOTE: Optional Quality Review and 2nd Level Review sections are the responsibility of appropriate Health Plan or Field Office staff.
20. Implementation of Quality Reviews during a CBAS Eligibility assessment can vary across assessing organizations.
    a. If your organization prefers to track a Quality Review of an individual CEDT then use the Optional Quality Review box to capture relevant review information. If this review is not tracked in this manner, please check the "Not Applicable" option in the Optional Quality Review box.
    b. A Quality Review must be completed by a person other than the Face-to-Face Assessor.
    c. If the Optional Quality Review outcome is "Agree with Assessor" and a "2nd Level Review is "Not Applicable", then check the respective "Not Applicable" boxes in those signature areas and the Face to Face Assessor Recommendation is considered the final outcome.
    d. If the Optional Quality Review outcome is "Disagree with Assessor" AND the Face-to-Face Assessor Recommendation is "The individual APPEARS TO MEET the criteria for Community Based Adult Services (CBAS)" then check the respective box in that signature area and proceed to a "2nd Level Review".
21. If a Second Level Review is required, complete the "2nd Level Review" information box in Section J.
    a. Second Level Reviews are minimally required for any "DOES NOT APPEAR TO MEET eligibility criteria for CBAS" outcome in Section I.
    b. Second Level Reviews are also required for any "Optional Quality Review" outcomes where the "Disagree with Assessor" check box is checked and the Face-to-Face Assessor Recommendation is "The individual APPEARS TO MEET the criteria for Community Based Adult Services (CBAS)".
    c. The outcome of a Second Level Review, when completed, is considered the final outcome.

22. Use the “Comment Page” for any additional information required to support Section J.

STATE OF CALIFORNIA
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**CBAS DISCHARGE SUMMARY REPORT INSTRUCTIONS**
CDA 4008i (REV 01/2022)

## Overview:

The CBAS Discharge Summary Report (CDA 4008) provides summary information on participant discharges that occur in Community-Based Adult Services (CBAS) centers.

Maintain the CBAS Discharge Summary Report for ALL Medi-Cal participants discharged from the center, on a cumulative basis annually, and provide the report to the CBAS Bureau under the following circumstances:

| | | |
|---|---|---|
| 1 | Upon discharge of a Medi-Cal fee-for-service (FFS) participant | Submit using the Peach Provider Portal at https://peach.aging.ca.gov/ **DO NOT EMAIL** |
| 2 | Upon CBAS Center Closure | Submit using the Peach Provider Portal at https://peach.aging.ca.gov/ **DO NOT EMAIL** |
| 3 | Upon request by CDA | When CDA requests the CBAS Discharge Summary Report, we will provide instructions on how to send thereport in a secure manner that protectsparticipant health information. |

NOTE: The CBAS Discharge Summary Report (CDA 4008) is a tracking document that includes limited summary data on all discharged participants. CBAS centers are still required to develop discharge plans for all participants as part of the six-month reassessment and at time of discharge. Discharge plans are to be maintained in the participants' health records.

## General Instructions:

Please complete one line of this form for each CBAS participant discharged from the center per the reporting requirements below for each calendar year. Report only Medi-Cal Managed Care and fee-for-service participants. Do NOT report private pay participants.

Administrator or Program Director must sign and date the form prior to submission.

## Header Instructions:

- Center Name – Enter the center's complete legal name
- NPI – Enter the center's National Provider Identifier (NPI)
- Year – Enter the year in which participant discharge(s) occurred

## Column Instructions:

A. Participant Name – Enter participant first and last name

B. Client Identification Number (CIN) – Enter participant Medi-Cal Client Identification Number (CIN)

C. First Date of Attendance – Enter participant first date of services at the CBAS center after initial assessment by the center's multidisciplinary team (mm/dd/yyyy)

D. Last Date of Attendance – Enter last date participant attended center prior to discharge (mm/dd/yyyy)

E. Date Discharged – Enter date center discharged participant per definition of discharge and reporting (mm/dd/yyyy)

## Column Instructions Cont.:

F. Reason for Discharge – Select reason for participant discharge from drop down menu:
   1. Death
   2. Nursing Facility Placement
   3. Managed Care Plan/DHCS Determined Ineligible
   4. Center Closure–Participant Declined Other Services
   5. Center Closure–CBAS Center Transfer
   6. Loss of Medi-Cal Eligibility
   7. Center Discontinued Services – per center discharge policies and procedures that meet Title 22 requirements such as:
      a. Participant fails to meet Participation Agreement requirements
      b. Participant no longer benefits from CBAS
      c. Participant requires higher level of care
   8. Participant Discontinued Services – by notifying the center of intent to discontinue for reasons such as:
      a. Participant transferred to another center
      b. Participant moved out of area
   9. Other (enter reason in comments column H)

G. Payer – Select participant payer from the drop–down menu – either Medi-Cal Managed Care plan or Medi-Cal fee-for-service

H. Comments – Enter other pertinent comments as needed

## Terms/Phrases:

Discharge – Each provider is required to maintain and follow policies and procedures for discharge that meet requirements of The California Code of Regulations, Title 22.

Section 54117 defines discharge as the termination of the participation agreement. The participation agreement specifies the types and duration of services to be provided each week and represents the agreement between the CBAS provider and the participant regarding care at the CBAS center.

Section 54213 describes conditions for participant discharge. Section 54223(a) specifies that attendance shall be regular and planned.

Because Title 22 does not specify a specific timeframe for discharge (i.e., the maximum number of days of absence from regular attendance at the center that terminates the participation agreement), for the purpose of uniform reporting on the CBAS Participant Discharge Summary Report (CDA 4008), CDA requests discharge data as follows:

**EITHER**

1. Participants discharged per the center's policies and procedures;

**OR**

2. Participants who are not in attendance for 60 days AND their authorization has expired

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**ADHC/CBAS INCIDENT REPORT**
CDA 4009 (REV 10/2020)

| | |
|---|---|
| Center Name: | |
| NPI: | |
| Name/Title of Person Completing Report: | |
| Incident Date: | Report Date: |

## Section I – Incident Information

Complete this section once only, even if multiple participants were affected. Report only adverse events that occur at the center or in transit to or from the center.

**A. Nature of Adverse Event**

Unusual Occurrences in Environment or Facility (Report within 24 Hours)

| | | | |
|---|---|---|---|
| Fire | ☐ | Catastrophes or Major Accidents | ☐ |
| Flood | ☐ | Equipment or Utility Failures resulting in closures | ☐ |
| Explosion | ☐ | Poisoning | ☐ |
| Earthquake | ☐ | Other | ☐ |
| Epidemic outbreaks reportable to local or state public health officials | | | ☐ |

Death, Serious Injury, and Unusual Incidents (Report within 48 Hours)

| | | | |
|---|---|---|---|
| Death | ☐ | Unexplained absence & inability to make contact | ☐ |
| Serious injury | ☐ | Protected Health Information Security Breach | ☐ |
| Abuse | ☐ | Participant missing from center | ☐ |
| Other | ☐ | | |

Summary/Additional Information. Briefly describe adverse event and center's response.

**B. Center Response (select all that apply):**

- Called 911 ☐
- Completed *Report of Suspected Dependent Adult/Elder Abuse (SOC 341)* ☐
- Initiated 5150 ☐
- Closed center ☐
- Coordinated with:
- *Emergency Contact(s)* ☐
- *Authorized Representative(s)/Conservator* ☐
- *Personal Health Care Provider(s) "PHCP"* ☐
- *Managed Health Care Plan(s)* ☐
- *County Public Health* ☐
- *County Mental Health* ☐
- Other (specify below) ☐

**C. Notification Submitted (select all that apply):**

- California Department of Aging, CBAS Branch ☐
- California Department of Public Health, Licensing District Office (enter District office below) ☐

_____

- Managed Health Care Plan(s) ☐
- Emergency Contact(s) ☐
- Authorized Representative(s)/Conservator ☐
- Local Long-Term Care Ombudsman ☐
- Adult Protective Services ☐
- Regional Center(s) ☐
- Law Enforcement ☐
- County Public Health ☐
- County Mental Health ☐
- Personal Health Care Provider(s) "PHCP" ☐

## Section II – Participant Information

Complete Sections II.A. and II.B. below for <u>each</u> participant affected by the adverse event. Use additional space provided to report multiple participants. For center-wide adverse events that did not result in participant harm do not complete Section II.

**A. Participant Identifying Information**

Name:

CIN:

Age:

Gender:

Enrollment Date:

Managed Care Plan:

**B. Participant Status/Outcome at Time of Report (select all that apply)**

- Transported for medical treatment ☐
- Transported home ☐
- Hospitalization ☐
- ER visit ☐
- Discharged from center ☐
- Nursing home placement ☐
- Death ☐
- Other ☐

If "Other" selected above, please specify:

STATE OF CALIFORNIA
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CDA 4009 (REV 10/2020)

| **A. Participant Identifying Information** | |
|---|---|
| Name: | |
| CIN: | |
| Age: | |
| Gender: | |
| Enrollment Date: | |
| Managed Care Plan: | |
| **B. Participant Status/Outcome at Time of Report (select all that apply)** | |
| Transported for medical treatment<br>Transported home<br>Hospitalization<br>ER visit<br>Discharged from center<br>Nursing home placement<br>Death<br>Other | ☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐ |
| If "Other" selected above, please specify: | |

STATE OF CALIFORNIA
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| **A. Participant Identifying Information** |
|---|
| Name: |
| CIN: |
| Age: |
| Gender: |
| Enrollment Date: |
| Managed Care Plan: |
| **B. Participant Status/Outcome at Time of Report (select all that apply)** |
| Transported for medical treatment ☐<br>Transported home ☐<br>Hospitalization ☐<br>ER visit ☐<br>Discharged from center ☐<br>Nursing home placement ☐<br>Death ☐<br>Other ☐ |
| If "Other" selected above, please specify: |

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
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| **A. Participant Identifying Information** |
|---|
| Name: |
| CIN: |
| Age: |
| Gender: |
| Enrollment Date: |
| Managed Care Plan: |
| **B. Participant Status/Outcome at Time of Report (select all that apply)** |
| Transported for medical treatment ☐<br>Transported home ☐<br>Hospitalization ☐<br>ER visit ☐<br>Discharged from center ☐<br>Nursing home placement ☐<br>Death ☐<br>Other ☐ |
| If "Other" selected above, please specify: |

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| **A. Participant Identifying Information** |
|---|
| Name: |
| CIN: |
| Age: |
| Gender: |
| Enrollment Date: |
| Managed Care Plan: |
| **B. Participant Status/Outcome at Time of Report (select all that apply)** |
| Transported for medical treatment ☐<br>Transported home ☐<br>Hospitalization ☐<br>ER visit ☐<br>Discharged from center ☐<br>Nursing home placement ☐<br>Death ☐<br>Other ☐ |
| If "Other" selected above, please specify: |