



**SAN FRANCISCO
HEALTH PLAN™**

Here for you

Community-Based Adult Services (CBAS) Manual

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CBAS Initial Assessment and Reassessment

San Francisco Health Plan (SFHP) ensures the initial assessment and reassessment procedures for Members requesting Community-Based Adult Services (CBAS), or who have previously been deemed eligible to receive CBAS by the Department of Health Care Services (DHCS), meet the requirements of the Medi-Cal Program, using appropriate staff that have received training on the assessment tool approved by DHCS.

SFHP contracts with the Department on Aging and Adult Services and the Institute on Aging (“CEDT Assessor”) to conduct the initial assessment and reassessment and is responsible to meet the CBAS requirements described below.

Referral and CBAS Eligibility Determination:

1. Individuals that may be eligible for CBAS with SFHP must already be SFHP members.
2. CBAS Provider or other referral source identifies a potential need for CBAS services for an SFHP member and submits a request for inquiry to begin the CBAS assessment process, including member’s physician’s history and physical information (H&P), with prescription medications, if any.
3. CEDT Assessor schedules Face-to-Face (F2F) with member, using the CBAS eligibility determine tool (CEDT).
4. CEDT Assessor acknowledges, in writing, to requestor and member, the inquiry and makes first attempt to schedule F2F within 5 calendar days.
5. CEDT Assessor makes two additional attempts via telephone to schedule between 5 and 8 calendar days of request.
6. CEDT Assessor makes final attempt in writing giving the member until day 14 to schedule F2F. If member does not schedule within 14 days from inquiry, CEDT Assessor will send a follow-up letter to member and requestor that if services are still needed a new inquiry must be submitted to begin the process again.
7. Administrative process will stop the F2F process, such as member does not meet the age criteria (less than 18 years old) or loss of Medi-Cal.
8. Follow-up letter will be sent identifying they do not meet the minimum qualifications to begin the F2F process.
9. CEDT 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 30 days from initial inquiry. Approval or denial of eligibility for CBAS to conduct IPC will be sent to the Center within 1 business day of decision.
 - c. Any decision for a denial will be made by the SFHP Medical Director, or physician designee.
 - d. Documentation for the F2F cannot include documents written by the CBAS center staff.
 - e. Documentation for the F2F includes documents provided by the member’s medical, mental health and social services providers.
10. Member has the right to choose a center, if the requesting provider is not a CBAS center.

11. 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.

CBAS Center IPC Initial Assessment and Authorization Requests

1. CBAS Center receives authorization from CEDT Assessor to conduct 3-Day IPC assessment (completed CEDT is sent to CBAS center).
2. CBAS center multi-disciplinary team performs 3-day assessment
3. Prior authorization request, including IPC with Level of Service recommendation is created and sent to CEDT Assessor
4. CEDT Assessor receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation.
5. CEDT Assessor will handle recommendations through existing prior authorization process which includes:
 - a. Submission of the Authorization form; and
 - b. Completed IPC.
6. CEDT Assessor will approve or modify the prior authorization request within 5 business days, in accordance with Health and Safety Code 1367.01
7. If the CEDT Assessor recommends a denial of a prior authorization, the CEDT Assessor will send the denial to SFHP for review.
8. Upon receipt of the denial recommendation from the CEDT Assessor, the SFHP Medical Director or physician designee, will review and make the determination for the denial. If a denial is determined, SFHP will issue the denial.
9. If CEDT Assessor or SFHP cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and center.
10. CEDT Assessor notifies Center within 24 hours of decision. Plan notifies member within 2 business days.

CBAS Authorization Requests

1. With approval of the CEDT from the CE Assessor, CBAS Center begins the multi-disciplinary evaluation and completes the IPC.
2. Centers are encouraged to complete the evaluation and IPC within 30 calendar days of the CEDT approval.
3. Upon completion of the IPC, CBAS Center Completes & Submits Prior Authorization Request:
 - a. CBAS center completes and sends the SFHP authorization form.
 - b. CBAS center submits the completed IPC with Level of Service recommendation, to the CE Assessor.
 - c. CBAS center submits documents via SFHP secure FTP folders or fax (415) 750-5335.
 - d. CE Assessor receives Authorization form, IPC and level of service request from CBAS center.
 - e. CE Assessor to approve, modify or deny prior authorization request within 5 business days, in accordance with Health and Safety Code 1367.01
4. If CE Assessor cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and center.
5. Upon decision CE Assessor, SFHP notifies center within 1 business days of decision.
6. SFHP notifies member within 2 business days of decision.

CBAS Claim Procedures

1. San Francisco Health Plan (SFHP) processes and adjudicates all claims from Community Based Adult Services (CBAS) centers for CBAS services provided to SFHP members, regardless of the member's medical group assignment. Medical groups are not delegated payment of CBAS. Claims are paid within 45-working days.
2. The claim receipt date is the day the electronic claim is first received by SFHP. Claims received after 5:00 pm on any given day are assigned the following day's receipt date.
3. CBAS centers submit claims electronically through the SFHP secure folders, in the EDI 837 5010 format.
4. SFHP uploads acknowledgement reports (997), remittance advice (RA, 835), error reports, and non-HIPAA compliant claims reports electronically to the secure folders of each CBAS center.
5. If all files are non-compliant, SFHP will provide the results in the non-HIPAA compliant folder.
6. If the claim file is partially compliant, CBAS center will receive an error report from RTZ.
7. CBAS claims submitted that have dates of service not authorized will be denied.
8. If claims are denied for lack of an authorization, but the center has a Treatment Authorization Request (TAR) from the Medi-Cal program, SFHP requires the CBAS center to submit the TAR for review. If the TAR is valid for the Dates of Service for the denied claims, SFHP will re-process the claim for payment.
9. To ensure continued access to CBAS, the CBAS center must follow up with a request for a reauthorization for CBAS from SFHP, include an updated IPC and level of service request.
10. Payments to Centers may be made via Electronic Fund Transfer.
11. SFHP shall issue a remittance advice with the payment or denial.
12. Claims submission has a one (1) year billing limit, similar to Medi-Cal. After six months from the service date, there is a payment reduction as defined by Medi-Cal regulations.
13. Duplicate claims submitted prior to sixty (60) days may cause delays in processing your claims. When submitting a duplicate claim, please indicate duplicate or rebill on the claim.
14. If a claim is denied, providers should resubmit the claim with the corrected information. A request for reconsideration of the claim must be submitted within one (1) year from the date of the Explanation of Benefits (EOB) on which the claim appeared as denied. Any errors on the original claim should be corrected at this time.
15. Timeliness limits will apply if the appropriate follow-up time is not acknowledged.
16. Reconsiderations require a copy of the original claim form with corrections and/or attachments. Corrections or additional information by line number are necessary to reconsider previously paid (underpaid/overpaid) and/or denied

claims. Additional information required on reconsideration in order to be reviewed for payment and/or additional payment may include the following:

- Retroactive eligibility
- Diagnosis
- Procedure code
- Counts or units of service
- Retroactive authorizations
- Underpayment/overpayment
- Medical records
- Chart notes

17. Reversals and/or adjustments to claims may be made as a result of, but not limited to:
18. Retroactive terminations (retroactive termination means a member was terminated in a prior month, but SFHP received notification in a later month).
19. If it is determined that the claim was handled correctly based on the information and documentation received by SFHP, the provider will be advised of the proper procedure for a provider dispute resolution.
20. For Authorizations and Claims questions, please contact UM CBAS Coordinator, (415) 615-5181.

Provider Dispute Resolutions (Appeals)

The SFHP Provider Dispute Resolution (appeals) process offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, or a claim adjustment, a method for resolving problems.

An appeal must be submitted in writing within 90 days of the decision on the original claim. Please use the Provider Dispute Resolution form. All appeals must be signed and each appeal should include only one member.

Do not submit an appeal if the claim is in a pend status. The provider may also include additional information that may affect the outcome of the appeal. For further instructions on how to file an appeal, please contact SFHP Claims Department at (415) 547-7818 ext. 7115, Monday through Friday, 9am-4pm.

Supporting Documentation

Necessary documentation should be submitted with each appeal to allow for a thorough review of the appeal. It is very important that all supporting documentation be legible. Include applicable attachments such as:

- a. Claim copy, corrected if necessary
- b. Copy of SFHP Explanation of Benefits Report
- c. Copy of eligibility screen or Medi-Cal ID cards
- d. Copy of all correspondence to and from SFHP to document timely follow-up
- e. Copy of authorizations

Verification of Timely Submission

The only acceptable documentation to verify timely submission of a claim is a copy of a SFHP Explanation of Benefits (EOB) or any dated correspondence from SFHP containing a Claim control number with a Julian date.

Resolution and Written Determination

SFHP will resolve each provider dispute or amended dispute in a written determination within 45 days of receipt of the appeal. Send all claim reconsiderations and appeals to:

San Francisco Health Plan
Attn: Claims Department
P.O. Box 19427
San Francisco, CA 94119

CBAS Re-Authorization Requests

1. San Francisco Health Plan (SFHP) and Community-Based Adult Services (CBAS) work together to ensure continuity of Community-Based Adult Services (CBAS) to eligible members.
2. For SFHP members with approved State Treatment Authorization Requests (TARs), SFHP will honor these TARs from October 1, 2012 through their expiration dates.
3. If an SFHP member has an expiring TAR, submit the SFHP authorization form with an updated Individual Plan of Care (IPC) with Level of Service Recommendations.
4. CBAS Center re-assesses participant and sends authorization request (SFHP Form), with IPC with Level of Service recommendation, to CBAS Eligibility (CE) Assessor.
5. CE Assessor receives authorization request from CBAS center, which includes the updated IPC and Level of Service recommendation.
 - a. CE Assessor will approve, modify or deny prior authorization request within 5 business days
 - b. If CE Assessor cannot make a decision within 5 business days, a 14-day delay letter will be sent to the member and center.
 - c. CE Assessor notifies SFHP within 1 business day of decision.
6. SFHP notifies Center within one business day of decision. SFHP notifies member within 2 business days of decision.
7. To deny or decrease the level of service, the CE Assessor must conduct a F2F with the member.
8. If the level of service request remains the same, the CE Assessor may request more information if the IPC does not provide enough current information. Additional information requests may include a summary of the client's current condition.
9. If an increase of level of service is requested, the CE Assessor may conduct a F2F if sufficient information is not provided.
 - a. CBAS center should not begin providing increased level of service until after receiving the authorization approval.
 - b. Dates of services noted should reflect the date the request is submitted. Reimbursement is not guaranteed until service level is approved.
 - c. 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)
 - e. SFHP receives the authorization form with the number of authorized days
 - f. SFHP reviews the new total of days requested on the form.
 - g. SFHP issues a Notice of Action letter, with the decision and includes a copy of the authorization form.
10. If there is a decrease in the number of days, the CE Assessor will notify the Center and SFHP by email. SFHP will then send a modification letter to the Center and member.

11. If member loses eligibility, the authorization is not valid. The member must be an effective member with SFHP.

Re-Authorization Process

1. CBAS center submits a request to begin the CBAS reassessment process for the following reasons:
 - a. Prior authorization end date is approaching
 - b. Due to a change in condition that would require a change in level of service.
2. CBAS Center sends Prior authorization request, including IPC with Level of Service recommendation, and sends to CEDT Assessor. Center indicates change of status, increase or decrease in days, additional medical information, etc.
3. CEDT Assessor receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation.
 - a. CBAS center may send the prior authorization request as early as the 1st of the month the prior to the month the auth will expire.
 - b. CBAS centers are encouraged to submit the authorization request by the 15th of the month that the authorization will expire.
4. If Member is already receiving CBAS and CBAS center requests that services remain at the same level, CEDT Assessor may authorize services using only the Member's IPC, including any supporting documentation supplied by the CBAS Provider.
5. If there is a change in the level of service, such as an increase in days, CBAS center needs to include supporting documentation with the IPC, which may include assessment, progress notes, physician's update, new diagnosis, new medications, etc.
6. CEDT Assessor shall not deny, defer, or reduce a requested level of CBAS for a Member without a F2F review, using the CEDT tool.
7. If the client requests a decrease in days, then a F2F is not needed.
8. If the center requests a decrease, but the client disagrees, Center must note the disagreement in the auth request. CEDT Assessor will then conduct a F2F using the CEDT tool.
9. CEDT Assessor will handle recommendations through the prior authorization process which includes:
 - a. CEDT Assessor will approve, modify or deny prior authorization request within 5 business days, in accordance with Health and Safety Code 1367.01
 - b. If CEDT Assessor cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and center.
 - c. CEDT Assessor notifies SFHP within 24 hours of decision.
10. SFHP notifies center within 1 business days of decision.
11. SFHP notifies member within 2 business days of decision
12. To deny or decrease the Prior Authorization request, the CEDT Assessor must conduct a F2F with the member.
13. Process must be completed in accordance with Health and Safety Code 1367.01 and ensure timelines are met.

Lapsed CBAS Authorization

1. When the SFHP member is away from the center (not attending on their previously scheduled days) for 3 months or longer, an authorization for CBAS may lapse or expire.
2. If the member has not yet returned to the CBAS center, the CBAS center will not be able to obtain a reauthorization from SFHP.
3. If and when the member returns to the CBAS center and the authorization, either from DHCS or SFHP, has expired more than three months ago, the CBAS center must submit a request for a CEDT, and then conduct all required assessments/reassessments unless lapse is due to hospitalization or other health-related issues.
 - a. If the TAR lapse is due to hospitalization, a CEDT will not be required.
 - b. If due to hospitalization or other health-related issues, the reauthorization process will be followed when the member is discharged and ready to resume CBAS.
4. If determined eligible by the CE Assessor (CEDT is completed and approved), then center must submit an authorization request, with level of service request, and IPC.
5. The CBAS center must ensure that all of the requirements for an initial admission are met, including a current TB clearance (must have been done and determined negative within one year of return to the CBAS center), a current home assessment (if there is reason to believe that the home situation has changed, the CBAS center must complete another home visit), and current MDT assessments, IPC and H&P as needed.
6. If the authorization lapse is less than three months, no CEDT is required.
 - a. If the participant returns before the current authorization period has ended, a new authorization is not necessary.
 - b. Center is required to submit to the CEDT Assessor the following:
 1. A request to reauthorize services when the authorization expires; and
 2. Updated IPC; and
 3. Level of service request.
 - c. In this case, a CEDT is not needed.

CBAS Proposed Change of Status

1. SFHP shall ensure that the initial assessment and reassessment procedures for Members requesting Community-Based Adult Services (CBAS), or who have previously been deemed eligible to receive CBAS, meet the requirements of the Medi-Cal Program, using appropriate staff that has received training on the assessment tool approved by the Department of Health Care Services.
2. SFHP contracts with the Department on Aging and Adult Services and the Institute on Aging (“CEDT Assessor”) to conduct the initial assessment and reassessment and is responsible to meet the CBAS requirements described below.
3. An authorization request and IPC must be submitted if the number of days approved on the current authorization must be increased due to a change in the participant’s condition or service needs.
4. The authorization form should indicate client’s current level of service and change of level of service being requested with supporting documentation (updated IPC, progress/assessment notes, medical/mental/social services documents).
5. The CBAS provider completes the increased level of service field and should not begin increasing CBAS level of service to the recipient until the center has received an adjudication response from the plan.
6. If the CBAS provider begins increasing CBAS level of service to the recipient prior to notification of the approved TAR, it is at the risk of no reimbursement if the plan does not authorize the recommended number of days requested.
7. Center does not have to resubmit if does not anticipate using all days.
8. CEDT assessor will notify the center within 5 business days of whether the assessor has approved the request with supporting documentation received, or if a F2F assessment is needed to authorize the request.
 - a. If CEDT assessor determines that there is sufficient documentation to approve the request, the center will be notified per the authorization form that the change of service has been approved by assessor.
 - b. If CEDT assessor determines a F2F is needed due to insufficient information, assessor will schedule a F2F assessment of the client with the center.
 - The CEDT will be used to conduct every F2F assessment.
 - CEDT Assessor will approve, modify or deny prior authorization request within 5 business days.
 - c. With any modification or denial, a CEDT will be attached for center to review.

CBAS Transfers from FFS or Anthem Blue Cross

1. San Francisco Health Plan (SFHP) and Community-Based Community Based (CBAS) centers shall work together to ensure members are receiving the appropriate levels of CBAS when switching from Medi-Cal Fee-for-Service (FFS) or Anthem Blue Cross.
2. A new member may have disenrolled from Anthem Blue Cross (ABC), or from Medi-Cal Fee-for-Service (FFS) and enrolled in San Francisco Health Plan (SFHP).
3. If the new member was determined to be eligible for CBAS by ABC or Medi-Cal FFS, SFHP will honor the ABC CBAS determination, with the approved CEDT and completed IPC and approved authorization from ABC or Medi-Cal FFS, if available. Using the SFHP Authorization form, choose "transfer from ABC or FFS" from the drop down menu, or write it on the form.
4. If the approved CEDT is not available, center must submit at least the authorization form from ABC or Medi-Cal FFS.
5. The effective date for CBAS with SFHP will be as of their enrollment in SFHP.
6. To facilitate the process, CBAS centers are to submit an authorization request form to CEDT Assessor using the SFHP Authorization form and include a copy of the ABC or Medi-Cal authorization form.
7. CBAS Center is to write "Transfer from Blue Cross or FFS" on the SFHP Auth form and send the form to the CE Assessor, or choose it from the drop down on the online SFHP form.
8. CE Assessor will review the request, verify the authorization for CBAS and determine CBAS eligibility with SFHP.
9. CE Assessor will send the decision of the authorization to SFHP.
10. SFHP Utilization Management (UM) staff will check for "Transfer from Blue Cross or FFS" on the form and will make the member CBAS eligible according to the dates approved on the SFHP Authorization form.

CBAS Transfers from Another CBAS Center

1. A member who recently attended or is currently attending one of the CBAS centers may decide to attend another CBAS center.
2. 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.
 - a. 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 CE Assessor.
 - b. CBAS Center is to select "Transfer from CBAS center" on the SFHP authorization form and send the form to the CE Assessor.
 - c. CE Assessor will review the request and verify the authorization for CBAS.
 - d. CE Assessor will send the decision of the authorization to SFHP.
3. 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.
4. The center the member is leaving must send SFHP the discharge plan.

Enhanced Case Management for Members Ineligible for CBAS

Enhanced Case Management

1. San Francisco Health Plan (SFHP) shall provide enhanced case management (ECM) benefits in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 92.b. and in addition to Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services.
2. SFHP may contract with a CBAS Provider or other appropriate entity (“designee”) for the provision of ECM services to eligible Members.
3. SFHP, or designee, shall ensure the provision of Enhanced Case Management (ECM) services from April 1, 2012, through August 31, 2014 to Members who received Adult Day Health Care (ADHC) services from Medi-Cal at any time between July 1, 2011 and February 29, 2012 and who are determined to be ineligible for CBAS.
4. A Member determined to be eligible for ECM may at a later date be determined eligible for CBAS.
5. If the Member receives CBAS, the Member will no longer receive ECM. If at a later time the Member no longer receives CBAS, the Member will then be eligible to receive ECM.
6. A Member eligible for ECM who receives CBAS at some time between April 1, 2012 and August 31, 2014, is eligible to receive ECM for any time period during which they do not receive the CBAS benefit. A Member shall not receive ECM and CBAS concurrently.
7. For Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS, Contractor shall continue to approve the provision of CBAS until ECM service referrals are made, a care plan has been developed, and Contractor has referred the Member to services as advised in the care plan.
8. SFHP, or designee, shall attempt to contact Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS a minimum of three (3) separate times to initiate ECM.
9. If the Member refuses to engage in ECM or SFHP, or designee, is unable to make contact with the Member after three (3) separate attempts, SFHP’s obligation will have been met.
10. SFHP, or designee, shall provide ECM services in accordance with the requirements in this provision if the Member requests it after outreach effort obligations have been met.

Expedited CBAS Assessment

Referral Procedures

1. San Francisco Health Plan (SFHP), through its designated CBAS Eligibility Determination Assessor, maintains an expedited assessment process to determine CBAS eligibility when informed of Members in a hospital, who are at high risk of admission to a skilled nursing facility, or are in a skilled nursing facility, whose discharge plan includes CBAS.
2. SFHP contracts with a CBAS Eligibility Assessor (CEDT Assessor) for expedited CBAS eligibility.
3. A Nursing Facility or Hospital may identify a potential need for expedited CBAS services in the discharge plan.
4. Nursing Facility or hospital provider may submit a request for CBAS assessment process.
5. Expedited process for such requests will be conducted with 5 business days.
6. CEDT Assessor schedules Face to Face (F2F) at the Nursing Facility or Hospital with member/facility immediately
7. CEDT Assessor F2F with member using the following guidelines:
 - a. CEDT Assessor must complete F2F within 5 business days.
 - b. F2F must be completed, using CEDT tool, within 5 business days from initial inquiry. Approval or denial of CBAS eligibility to conduct IPC will be sent to the Center within 1 business day of decision.
 - c. Member's has the right to choose a center, if the requesting provider is not a CBAS center.

CBAS Center Procedures

1. Receives approval from CEDT Assessor to conduct 3 Day IPC assessment
2. CBAS center multi-disciplinary team performs 3-day assessment
3. Prior authorization request, including IPC with Level of Service recommendation is created and sent to CEDT Assessor.
4. CEDT Assessor receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation.
5. CEDT Assessor will handle recommendation through existing prior authorization process which includes:
 - a. Plan will approve, modify or deny prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)
 - b. Plan notifies Center within 24 hours of decision. Plan notifies member within 48 hours of decision. F. CBAS services begin

CBAS Discharge Plans

Discharge Plan requirements

CBAS Centers are responsible to discharge of participants, including those who disenroll from the CBAS program by choosing to remain in Fee-For-Service (FFS) Medi-Cal.

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 (# 91.c-pg 45):
 - The participant's Client Identification Number (CIN)
 - The name(s) of the participant's physician(s)
 - The date the participant received notice of pending discharge
 - The date CBAS services are to end
 - Specific information about the participant's current medical condition, treatments, and medication regimen
 - A statement about Enhanced Case Management services and how they are available to eligible beneficiaries
 - The signature of the beneficiary or representative and the date signed.
3. Provide a reason on the form for the discharge from the following list:
 - Death
 - Long-term nursing facility placement
 - Other services obtained (e.g. care in the home, assisted living, etc.,)
 - Participant moves
 - Voluntary discharge
 - Transferred to another CBAS center
 - Other
4. Upon discharge from the center, provide copies of the participant discharge plan to:
 - The participant; **and**
 - Centers are to upload the discharge plan to the secure SFHP FTP site, "Miscellaneous" folder, using the nomenclature, "mmddyyyy[Member SHFP ID]dischargeplan.pdf"

DEFINITIONS

CBAS: Community-Based Adult Services

CEDT Assessor: Community-Based Adult Services Eligibility Determination Tool Assessor, contracted by San Francisco Health Plan to conduct initial assessments and reassessments.

Expedited CBAS Assessment: Request from a Nursing Facility or Hospital for CBAS assessment for an SFHP member.

Member: an individual that is enrolled in the San Francisco Health Plan Medi-Cal line of business.

Enhanced Case Management (ECM): is a service consisting 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 enrollees and/or his designees.

ECM Eligibility: From April 1, 2012, through August 31, 2014, the ECM benefit will be available to all Medi-Cal beneficiaries who:

- a. Received ADHC services through the California Medicaid program at any time from July 1, 2011 through February 29, 2012.
- b. Have been determined to be ineligible for CBAS or who are eligible for CBAS but exempted from enrolling in managed care and choose to receive ECM as a fee-for-service benefit rather than the CBAS benefit through a managed care plan.
- c. A Medi-Cal beneficiary determined to be eligible for ECM may, at a later date, be determined eligible for CBAS. If the enrollee then receives CBAS, he/she will no longer receive ECM. If at a later time the enrollee no longer receives CBAS, he/she will be eligible to receive ECM.
- d. An ECM-eligible enrollee who receives CBAS at some time between April 1, 2012, and August 31, 2014, is eligible to receive ECM for any time period during which they do not receive the CBAS benefit. A beneficiary shall not receive ECM and CBAS concurrently.

ECM Benefits: The following services will be provided as ECM to all eligible SFHP Members:

- a. Complex Case Management Services means the systematic coordination and assessment of care and services to enrollees who require the extensive use of resources and who need assistance navigating the services system to facilitate the appropriate delivery of care and services,
- b. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services;
- c. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the individual, includes;
 - 1) activities such as ensuring the active participation of the eligible individual, and
 - 2) working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and identify a course of action to respond to the assessed needs of the eligible individual
- d. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services;
- e. Monitoring and follow-up activities; and
- f. Person-Centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Complex Case Management and Discharge Planning, in compliance with STC 81.f.iv.

BEST PRACTICES TO FACILITATE CLAIMS PAYMENTS

1. The following are important to keep in mind when submitting a claim:
 - a. List the auth number on the claim.
 - b. Check to make sure the claim does not include billing for more units than were approved.
 - c. Double check to make sure duplicate claims are not submitted.
 - d. Notify SFHP by email to Liane Molyneaux, lmolyneaux@sfhp.org, if you do not receive your remittance advice.

2. Verify Eligibility - Although SFHP members are issued ID cards, member eligibility should always be verified prior to providing care. Eligibility can change from month to month. There are three ways to verify eligibility:
 - a. Web Site www.sfhp.org/providers, then log on to the secure provider area
 - b. Interactive Voice Response 415-547-7810
 - c. Member services 415-547-7800

3. Check to make sure invalid CBAS ICD10 code (listed below) are not included.

STAFF CONTACT OR CENTER CHANGE REQUESTS

1. Contact Nina Maruyama, nmaruyama@sfhp.org, to change a contact at the CBAS center for the following roles:
 - a. Email list for CBAS conference calls.
 - b. CBAS contact for secure folders
 - c. Banking changes

REFERENCES

[California Bridge to Reform Special Terms and Conditions April 1 2012](#)

REVISION HISTORY

Effective Date: October 1, 2012
Revision Date(s): April 18, 2014
October 10, 2014
October 2016