San Francisco Health Plan℠

Community Based Adult Services (CBAS) Manual

Revised February 5, 2025

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Overview

As of July 1, 2012, San Francisco Health Plan (SFHP) assumed the benefit provision responsibility for services provided at Community Based Adult Service (CBAS) Centers. This benefit was formerly administered by the California Department of Health Care Services (DHCS) through the Adult Day Health Care (ADHC) Program, which terminated on March 31, 2012.

The CBAS benefit is designed to restore eligible Medi-Cal member's optimal capacity for self-care and prevent premature and unnecessary institutionalization. SFHP stresses partnership with the member, member's family and/or caregiver, health care providers, and the community in working towards maintaining the member's personal independence.

Through SFHP's CBAS benefit, eligible members have access to a variety of facility-based services, which may include: professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; hot meals and nutritional counseling; and transportation, when medically necessary as indicated in the member's approved Individual Plan of Care (IPC).

SFHP contracts with the Institute on Aging (IOA) to have a registered nurse with an active license in good standing conduct eligibility assessments using the DHCS approved CBAS Eligibility Determination Tool (CEDT).

Effective October 1, 2022, CBAS Emergency Remote Services (ERS) will be implemented. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings other than the CBAS center (e.g., community, participant's home, or telehealth) during specified emergencies. The purpose of ERS is 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.

Procedures

SFHP ensures members requesting Community Based Adult Services (CBAS) receive an initial eligibility assessment and biannual reassessments (every six months) in accordance with DHCS contractual requirements.

SFHP contracts with the Institute on Aging (IOA), hereafter referred as "CEDT Assessor", who is a registered nurse, to conduct all eligibility assessments using the DHCS approved CEDT tool. SFHP oversees that appropriate CEDT Assessor staff conducts the eligibility assessments and receive training on the CEDT tool.

I. CBAS Referral

SFHP's CBAS benefit is available to eligible Medi-Cal members who are 18 years of age or older. To refer a member for CBAS services, the requestor must contact the CEDT Assessor. A CBAS Referral Form must be submitted to the CEDT Assessor before any assessment or services are provided by the CBAS Center, and prior to submission of a Prior Authorization Request. This referral will include the following:

1. Member Identifiers (Name/DOB/SFHP ID #)
2. Specific reasons CBAS services are being requested
3. Member's supporting medical history and physical information (H&P) from referring provider; and
4. Member's prescription medications, if any.

II. Initial Face-to-Face (F2F) Eligibility Assessment: Standard Request

1. Upon receipt of a ***standard*** inquiry request for CBAS evaluation, CEDT Assessor will send a written acknowledgement of the request to the requestor and the member.
2. Within five calendar days of the request, CEDT Assessor will make the first attempt to schedule the member's initial F2F assessment.
3. If initially unable to reach the member or member's representative, two additional telephonic attempts will be made between five and eight calendar days of the request.
4. If still unable to reach the member, CEDT Assessor will make a final attempt in writing giving the member until day 14 to schedule. If the member does not schedule an appointment within 14 days from the date of request, CEDT Assessor will advise the member and the requestor, in writing, that if the member continues to need CBAS services a new request will be required.
5. Members who are reached will have an F2F assessment appointment scheduled within 14 calendar days from receipt of the initial request.
6. The CEDT Assessor must complete the eligibility assessments using the DHCS approved CBAS Eligibility Determination Tool (CEDT) within 30 calendar days from the initial request.
7. Upon completion of the initial F2F eligibility assessment, CEDT Assessor forwards the completed CEDT tool to the CBAS Center within one business day of decision.

a. If the CEDT Assessor recommends CBAS eligibility approval, CEDT Assessor notifies the CBAS Center to conduct the three-day IPC assessment.
b. If the CEDT Assessor recommends CBAS eligibility denial, the completed CEDT and supporting documentation are forwarded to SFHP's Medical Director or physician designee for determination. If the decision is made to deny, a Notice of Action (NOA) denial letter including grievance and appeal rights is sent to the member, the provider, and CBAS Center explaining reason for denial.

III. Initial Face-to-Face (F2F) Eligibility Assessment: Expedited Request

1. SFHP, through its CEDT Assessor, offers an expedited F2F assessment process to determine CBAS eligibility when informed the member is in a hospital or skilled nursing facility whose discharge plan includes CBAS, or who are at high risk of admission to a skilled nursing facility.
2. Hospital or Nursing Facility staff that identifies a potential need for expedited CBAS services may submit a request to CEDT Assessor.
3. Upon receipt of an expedited inquiry request for CBAS evaluation, CEDT Assessor will complete the F2F virtually or onsite at the hospital or SNF facility within five business days.
    - A F2F assessment may be waived when an SFHP UM Nurse or Medical Director determine through another process (i.e., review of clinical information) that the member is clinically eligible and in need of CBAS services to be expedited.
4. The F2F assessment must be completed using the DHCS approved CEDT tool.
5. Upon completion of the F2F assessment, CEDT Assessor forwards the completed CEDT assessment to the CBAS Center within one business day of decision.
    a. If the CEDT Assessor recommends CBAS eligibility approval, CEDT Assessor notifies the CBAS Center to conduct the three-day IPC assessment.
    b. If the CEDT Assessor recommends CBAS eligibility denial, the completed CEDT and supporting documentation are forwarded to SFHP's Medical Director or physician designee for determination. If the decision is made to deny, a Notice of Action (NOA) denial letter including grievance and appeal rights is sent to the member, the provider, and CBAS Center explaining reason for denial.

IV. Individualized Plan of Care (IPC)

1. Upon notification of eligibility approval, CBAS Center's multi-disciplinary team performs a three-day assessment.
2. Upon completion of the three-day assessment, the multi-disciplinary team will have developed an IPC.
3. The IPC will include the anticipated Level of Service (LOS), medical diagnoses, prescribed medications, planned frequency of individual services linked to individual objectives, therapeutic goals, and duration of service(s), an individualized activity plan designed to meet the needs of the member for social and therapeutic recreational activies, transportation needs, special diet requirements, dietary counseling and education, if needed, a plan for any other necessary services that the CBAS center will coordinate.
    - IPCs will be reviewed and updated no less than every six months by the CBAS staff, the member, and their support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.
4. CBAS Center must then electronically submit all necessary information required to make a medical necessity determination to CEDT Assessor for review. Necessary information includes:

a. IPC
b. LOS
c. Clinical Documentation
d. Prior Authorization Request using the SFHP/CBAS Prior Authorization Request form
e. Indication of Request Priority- Expedited or Standard

5. This electronic submittal begins the formal Prior Authorization Request process.

V. Prior Authorization Requests

CEDT Assessor's Role

1. The CBAS Center's electronic submission to CEDT Assessor initiates the formal Prior Authorization Request process.
2. The requested authorization priority (standard/expedited) begins the standard or expedited decision making timeframe.
3. If the CBAS Center's electronic submission includes all necessary information required to make a medical necessity determination, CEDT Assessor reviews and provides the authorization determination recommendations to SFHP within one business day for expedited requests or within three business days for standard requests.
4. If the CBAS Center's electronic submission does not include the necessary information, CEDT Assessor will notify SFHP's CBAS contact, within one business day, via email.
   SFHP's CBAS contact:
   - **Long- Term Care Team**
     - **Fax**: 415-943-9700
     - **Direct Phone**: 415-615-4530
     - **Email**: longtermcarehelp@sfhp.org
5. SFHP contacts the CBAS Center and, if needed, the member or member's representative. If response is not received within 14 calendar days from electronic Prior Authorization Request submission, SFHP may choose to defer or deny the request, in accordance with the California Health and Safety Code 1367.0.

SFHP's Role

1. SFHP's CBAS contacts receive completed authorization recommendations for the member's IPC-LOS from CEDT Assessor.
2. CEDT Assessor submits all authorization recommendations to SFHP via fax.
3. If the CEDT Assessor recommends a reduction (partial denial) or denial to the requested IPC-LOS, an email is immediately sent to SFHP's CBAS contacts. Upon receipt of such email, SFHP's CBAS contacts forward the completed CEDT and supporting documentation to a SFHP physician reviewer for IPC-LOS review and determination.

- ***Potential Outcomes***

  Note: All authorization decision timeframes begin when CBAS Center submits IPC-LOS authorization request to CEDT Assessor. CEDT Assessor and SFHP share the standard or expedited decision making timeframe as indicated above in section V.1-4. SFHP ensures authorization decision timeframes are in accordance with the California Health and Safety Code 1367.01

a. If CEDT Assessor recommends approval, SFHP issues an approval letter to the member, the provider, and the CBAS Center within five business days for ***standard*** requests or within 72 hours for ***expedited*** requests.
    i. Approved IPC-LOS authorizations are created with a 12-month effective period.
        a. CEDT Assessor continues to perform the required biannual eligibility reassessment, every six months.
        b. Notification to SFHP after the reassessment is only required if CEDT Assessor recommends IPC-LOS reduction, increase or eligibility denial.
b. If CEDT Assessor and SFHP cannot make a decision due to insufficient information and have requested the information without response, a SFHP physician reviewer may choose to defer (extend) the decision timeframe or deny the authorization request on the 14th day after authorization request receipt.
    i. If deferral is determined by SFHP's physician reviewer, a notice of deferral, extending the decision time for an additional 14 calendar days, will be sent to the member, the provider, and the CBAS Center.
    ii. If denial is determined by SFHP's physician reviewer, a Notice of Action (NOA) denial letter will be sent to the member, the provider, and the CBAS Center explaining the reason for denial. This NOA will include the member's Medi-Cal grievance and appeal rights.
c. If the CEDT Assessor recommends reduction (partial denial) or denial of the requested IPC-LOS, the authorization will be reviewed by an SFHP Medical Director or physician designee for final determination.
    i. Upon completion of the physician review, the final authorization decision will be provided to the CEDT Assessor within 24-hours of the decision.
    ii. SFHP will notify the member, the provider, and the CBAS Center of partial denial or denial via NOA letter within five business days for ***standard*** requests or within 72 hours for ***expedited*** requests.
    iii. The NOA letter for all partially denied or denied CBAS services will include a clear and concise explanation of why services were denied. The NOA will include the member's Medi-Cal grievance and appeal rights.

VI. Eligibility Reassessments and Reauthorization Process

1. To continue receiving CBAS services, members previously deemed eligible (during initial F2F assessment) will receive biannual reassessments in accordance with DHCS contractual requirements.
2. Eligibility reassessments are completed by the CEDT Assessor using the member's updated IPC-LOS documentation supplied by the CBAS provider and the DHCS approved CEDT tool.
3. CBAS Center submits a request to begin the CBAS reassessment process for the following reasons:
    a. Biannual reassessment date is approaching (every six months);
    b. Annual prior authorization end date is approaching; or
    c. Due to a change in status that would require a change in the member's IPC-LOS.
4. CBAS Center sends a new Prior Authorization Request form, including updated IPC-LOS, to CEDT Assessor. CBAS Center will indicate any changes of status, increases or decreases in days, additional medical information, etc.

   a. If the member is already receiving CBAS services and the CBAS Center requests that services remain at the same level or be increased due to a change in level of need, CEDT Assessor may conduct the reassessment using only the member's IPC-LOS documentation supplied by the CBAS Provider. No F2F review is required.
   b. If there is a denial, deferral or reduction in the requested level of CBAS for a member, a F2F review must be performed by the CEDT Assessor using the DHCS approved CEDT tool.
   c. If the CBAS Center requests a decrease, but the member disagrees, the CBAS Center must note the disagreement on the Prior Authorization Request form. A F2F review must be performed by the CEDT Assessor using the DHCS approved CEDT tool.
5. CEDT Assessor shall not recommend partial denial or denial of a requested CBAS service without completing a F2F review, using the CEDT tool.
6. CEDT Assessor will provide all authorization determination recommendations through SFHP's existing prior authorization process as outlined above under section V. Prior Authorization Requests.

VII. Emergency Remote Services (ERS)

CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings other than the CBAS center (e.g., community, participant's home, or telehealth) during specified emergencies. ERS is defined in the California Department of Aging (CDA) All-Center Letter, ACL 22-04, Launch of New CBAS Emergency Remote Services (ERS). The purpose of ERS is 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. ERS is available to CBAS participants as needed and when ERS policy criteria are met. The initiation of ERS is defined in ACL 22-06, Initiation of CBAS Emergency Remote Services (ERS) and Completion of the CBAS ERS Initiation Form (CEIF) (CDA 4000).

When ERS is delivered in the participants home, CBAS providers are subject to Electronic Visit Verification (EVV) requirements. EVV is a telephone and computer-based solution that electronically verifies in-home service visits occur. CBAS providers must report the following in-home service activities through the EVV portal: type of service performed; individual receiving the service; date of the service; location of service delivery; individual providing the services; and time the service begins and ends.

Who May Receive ERS

1. Current CBAS participants with the following documentation in place:
   a. Approved IPC-LOS and Authorization.
   b. Signed CBAS Participation Agreement

Circumstances for ERS

1. Participant is experiencing a Public Emergency such as state or local disaster, 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, Tuberculosis, Norovirus, etc.
2. Participant is experiencing a Personal Emergency such as illness, injury, crises, or care transitions. Specific personal emergencies may include serious illness or injury*, crises**, care transitions such as to/from nursing facility, hospital, home*** as defined below:

*Serious Illness or Injury means that the illness or injury is preventing the participant from receiving CBAS within the facility AND providing medically necessary services and supports are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain.

**Crises mean that the participant is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises would be the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.

***Care Transitions refers to transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and participant/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

Determining Need for ERS

1. For ERS to be approved, the participant must experience a public or personal emergency AND need the services and supports CBAS provides under ERS.
2. In determining the initial need for and/or duration of ERS, the following is considered:
    a. Medical necessity - meaning that services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain. Since CBAS participants are determined to meet medical necessity criteria for center-based services during the eligibility determination and authorization approval processes, ERS must address needs when center-based care plan services are prevented or restricted.
    b. Hospitalization – whether the participant has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center
    c. Restrictions set forth by the participant's primary/personal health care provider due to recent illness or injury
    d. Participant's overall health condition
    e. Extent to which other services or supports meet the participant's needs during the emergency
    f. Personal crises such as sudden loss of caregiver or housing that threaten the participant's health, safety, and welfare

Services and Supports Included in ERS

1. CBAS providers must continue to provide supports and services specified in participants' authorized IPCs, as appropriate and feasible during the time of emergency.
2. Additionally, ERS supports and services to be provided include:
    a. Regular communication with the participant, including the following performed by a center multidisciplinary team member at least weekly during provision of ERS:
        i. Review and update of the ERS participant's health and functional status based on emerging needs
        ii. Review of the care plan for ERS and adjustments made as indicated
    b. Phone and email access for participant and family support six hours daily, Monday through Friday
    c. Assessment of participants' and caregivers' current and emerging needs
    d. Response to needs through targeted interventions
    e. Communication and coordination with participants' networks of care supports
    f. Identification of equipment/technology needs and assistance with telehealth
    g. Delivery of services and visits in-person if barriers to telehealth exist
    h. Delivery of/arranging for delivery of food, medications, and/or supplies. Meal delivery limited to no more than two meals per day.

Timeframe for Provision of ERS to a Participant

1. Provision of ERS supports and services is temporary and time limited.
    a. Short-term: Participants may receive ERS for an emergency occurrence for up to three consecutive months.
    b. Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three consecutive months without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the IPC.
    c. ERS End Date: An ERS incident ends when:
        i. The precipitating emergency is resolved and the participant can return to the center to receive care plan services and supports.
        ii. CEDT Assessor recommends and SFHP's Medical Director determines ERS is no longer appropriate and/or that the participant requires alternative supports and services.
        iii. The participant's existing CBAS authorization expires without reauthorization.

Initiation of ERS

I. CBAS Center registered nurse and/or social worker (per scope of practice) assesses/evaluates the participant/caregiver's current status and emerging needs to determine:
    a. Participant's status relative to their existing person-centered plan at time of emergency;
    b. Participant's need for specific supports and services at time of emergency; and
    c. Whether the CBAS provider can meet the participant's needs and/or if additional services and supports are needed.
        i. NOTE: If the CBAS provider determines it cannot meet a participant's needs during an emergency that would otherwise indicate the need for ERS, the CBAS provider must coordinate with SFHP and make referrals to alternative service providers and/or discharge the participant as appropriate and required by CBAS requirements.

II. CBAS Center informs the participant/caregiver of services and supports needed, including by agencies other than the CBAS provider, and obtain consent for ERS if the participant chooses.

III. CBAS Center completes the CEIF (CDA 4000), which includes:
    a. Date of emergency and date of participant/caregiver consent for ERS;
    b. Nature of emergency; and
    c. Participant's identified needs and ERS care plan that addresses supports and service needs and demonstrate that the participant meets ERS criteria.

IV. CBAS Center completes the SFHP/CBAS Prior Authorization Request form.
    a. Selection of ERS
    b. Requested ERS duration (not to exceed three consecutive months)

Initial Authorization of ERS

1. Within three working days after the start of ERS, CBAS Center sends a copy of completed CEIF (CDA 4000) and SFHP/CBAS Prior Authorization Request form to CEDT Assessor for review.
    a. In cases of widespread emergency affecting multiple participants at a CBAS Center, CEDT Assessor and SFHP will allow additional time for completion of the CEIF (CDA 4000) and SFHP/CBAS Prior Authorization Request form.
2. Authorization decision timeframes begin when the CBAS Center submits the ERS authorization request to the CEDT Assessor. CEDT Assessor and SFHP share the standard (5 business days) or expedited (72 hours) decision-making timeframe.

3. CEDT Assessor provides ERS authorization determination recommendations to SFHP.
    a. If CEDT Assessor recommends approval, SFHP issues an approval letter to the member, the provider, and the CBAS Center.
    b. If the CEDT Assessor recommends ERS denial, the completed CEIF (CDA 4000) and supporting documentation are forwarded to SFHP's Medical Director or physician designee for determination. If the decision is made to deny, a Notice of Action (NOA) denial letter including grievance and appeal rights is sent to the member, the provider, and CBAS Center explaining reason for denial.
4. If the dates of service requested are covered by an existing CBAS authorization, the existing authorization is used. If the existing authorization is nearing expiry, SFHP will extend the authorization end date through the three-month ERS period.

Reauthorization of ERS

1. ERS for an emergency occurrence may not exceed three consecutive months without assessment and review for possible continued need for remote/telehealth delivery of services and supports.
2. For any participant whose emergency indicates a need for extending ERS beyond three months, an updated IPC, CEIF (CDA 4000) and SFHP/CBAS Prior Authorization Request form is required.
3. Completed forms must be submitted to CEDT Assessor at least one-week prior to expiration of the existing ERS approved end date.
    a. In cases of widespread emergency affecting multiple participants at a CBAS center, CEDT Assessor, and SFHP will allow additional time for completion of the CEIF (CDA 4000) and SFHP/CBAS Prior Authorization Request form.
4. Authorization decision timeframes begin when the CBAS Center submits the ERS authorization request to the CEDT Assessor. CEDT Assessor and SFHP share the standard (5 business days) or expedited (72 hours) decision-making timeframe
5. CEDT Assessor provides ERS authorization determination recommendations to SFHP.
    a. If CEDT Assessor recommends approval, SFHP issues an approval letter to the member, the provider, and the CBAS Center.
    b. If the CEDT Assessor recommends ERS denial, the completed CEIF (CDA 4000) and supporting documentation are forwarded to SFHP's Medical Director or physician designee for determination. If the decision is made to deny, a Notice of Action (NOA) denial letter including grievance and appeal rights is sent to the member, the provider, and CBAS Center explaining reason for denial.
6. If the dates of service requested are covered by an existing CBAS authorization, the existing authorization is used. If the existing authorization is nearing expiry, SFHP will extend the authorization end date through the three-month ERS period.

VIII. CBAS Services

CBAS benefits include the following:

Core Services: Professional nursing care, personal care and/ or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS member on each day of service as follows.

I. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.

II. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

III. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.

IV. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities. The CBAS physical therapy and occupational therapy and occupational therapy maintenance programs are considered part of Therapeutic Activities.

V. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

Additional Services: The following additional services shall be provided to all eligible CBAS member as needed and as specified on the person's IPC: Restorative physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the Health and Safety Code (H&S Code), physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

I. Restorative occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the H&S Code, occupational therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

II. Speech therapy provided by a licensed, certified, or recognized speech therapist or speech therapy assistant within their scope of practice to restore function when there is an expectation that the participant's condition will improve significantly in a reasonable period of time as determined by the multidisciplinary assessment team.

III. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.

IV. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.

V. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

IX. CBAS Facility Selection

The member may choose any CBAS Center as long as it is within the selected facility's time and distance criteria for transportation.

X. 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 CBAS Center and is still within their current Centers 12-month authorization period, a F2F reassessment may not be required.
    a. To determine when F2F reassessments are required, refer above to section VI. Eligibility Reassessments and Reauthorization Process section (#4-5).
3. The CBAS Center the member is transferring to must submit a copy of the member's latest authorization letter with a new Prior Authorization Request to the CEDT Assessor.
4. CBAS Center is to select "Transfer from CBAS Center" on the SFHP/CBAS Prior Authorization Request form.
5. The transfer request must include a new IPC-LOS completed by the CBAS Center the member is transferring to.
6. CEDT Assessor reviews request and provides authorization determination recommendations to SFHP within one business day for expedited requests or within two business days for standard requests.
7. SFHP generates an authorization for the new CBAS Center the member is transferring to. SFHP follows the authorization process outlined above in section V. Prior Authorization Requests.

From Fee-for-Service (FFS), Kaiser, or Anthem Blue Cross

1. SFHP and CBAS Centers shall work together to ensure members are receiving the appropriate CBAS services when switching from Medi-Cal Fee-for-Service (FFS), Kaiser, or Anthem Blue Cross (ABC).
2. A new member may have disenrolled from ABC, Kaiser, or from Medi-Cal FFS and enrolled in SFHP.
3. If the new member was determined to be eligible for CBAS services by ABC, Kaiser, or Medi-Cal FFS, SFHP will honor the CBAS determination, with the approved CEDT, completed IPC-LOS, and approved Treatment Authorization Request (TAR), if available.
4. If the approved CEDT assessment is not available, the CBAS Center must submit the approved TAR form from ABC, Kaiser or Medi-Cal FFS.
5. The effective date of CBAS services with SFHP will coincide with the members SFHP enrollment date.
6. To facilitate the process, CBAS Centers submit a Prior Authorization Request form to the CEDT Assessor using the SFHP/CBAS Prior Authorization Request form and include a copy of the ABC, Kaiser, or Medi-Cal TAR form.
7. The CBAS Center must select "Transfer from Anthem Blue Cross, Kaiser, or Medi-Cal FFS" on the Prior Authorization Request form and send the form to the CEDT Assessor.
8. CEDT Assessor reviews request and provides authorization determination recommendations to SFHP within one business day for expedited requests or within two business days for standard requests.
9. SFHP generates an authorization for the CBAS Center following the authorization process outlined above in section V. Prior Authorization Requests.

XI. Retrospective Authorizations

1. CBAS services require prior authorization. If a prior authorization is not obtained, SFHP applies its retrospective authorization policy.
2. Retrospective requests must be submitted no later than 30 calendar days after the date of service AND must meet one of the conditions below. Authorization requests received later than 30 calendar days after the date of service are denied.
3. Retrospective and prior authorization requests cannot be combined. Retrospective service requests must be submitted separately and include the number of units (days) rendered. SFHP is required to create two separate authorizations.
   Retrospective authorization requests are only considered under the following conditions:
   a. Member receives retrospective eligibility;
   b. Certification of the Medi-Cal beneficiary's eligibility by the county welfare department was delayed;
   c. Member does not identify himself/herself to the provider as a SFHP member by deliberate concealment, or because of physical or mental incapacity;
   d. Non-emergency medical transportation;
   e. DME and medical supplies delaying hospital discharge;
   f. Professional fees for radiology and pathology, received retrospectively, and connected with an approved service; or
   g. Beneficiary is transitioning into Medi-Cal Managed Care from Medi-Cal FFS and is requesting continuity of care. Provided that these services have occurred after the member's enrollment into SFHP and that SFHP has the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into SFHP (per DHCS APL 18-008).
4. For retrospective authorization requests, the decision is made within 30 calendar days of receipt of the request. The requesting provider is notified of the decision to approve, deny, or partially deny the authorization request verbally or in writing via fax within 30 calendar days of the receipt of the request.

XII. Lapsed CBAS Authorizations

1. When the SFHP member is away from the CBAS Center (not attending their previously scheduled days) for three months or longer, the Prior Authorization 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 reauthorization from SFHP.
3. If and when the member returns to the CBAS Center and the SFHP Prior Authorization has expired more than three months ago, the CBAS Center must submit a request for a CEDT F2F re-assessment as outlined above in section II. Initial Face-to-Face (F2F) Eligibility Assessment.
4. If the member's lapse was due to hospitalization or other health-related issues, the re-authorization process will be followed as outlined above in section VI. Re-Authorization and Assessment Process.

XIII. Discharge from CBAS Services

1. CBAS Centers are required to complete CBAS Discharge Plans for any member no longer receiving CBAS services, 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. Discharge plan must include the following:

a. The Member's name and ID number
b. The name(s) of the Member's physician(s)
c. Date the member received notice of pending discharge
d. Date the CBAS benefit will be terminated
e. Specific information about the Member's current medical condition, treatments, and medications
f. Reason for discharge which may include:
    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
g. A statement of how Enhanced Case Management services will be provided to the Member if eligible for these services
h. Signature from the member or the member's representative and the date signed (if attainable)

3. Upon discharge plan completion, CBAS Center will provide copies of the member's discharge plan to:
    a. The member; and
    b. SFHP via upload to the secure SFHP FTP site, "Miscellaneous" folder, using the nomenclature, "mmddyyyy [Member SHFPID]dischargeplan.pdf".

XIV. Unbundled Services

1. If a member's needs are determined to exceed the capacity of a particular CBAS facility, or if there is a 5% change from the San Francisco County capacity as of April 1, 2012, SFHP shall coordinate access to unbundled services in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions (STC). As stated in the STC, SFHP will authorize unbundled services and facilitate utilization through care coordination. If there is a negative change of 5% or greater for any reason, SFHP shall report the negative change to DHCS and SFHP shall provide all Core Services and additional CBAS services on an unbundled basis.
2. If no CBAS facility is available, SFHP will assist the member in arranging services aligned with the approved SFHP benefits and assist the member in making appropriate referrals to other agencies for the unbundled, non-SFHP services and benefits (i.e., "Carve Outs").
3. With all eight CBAS centers in San Francisco fully operational and contracted with SFHP, it is unlikely SFHP will need to authorize or arrange for Unbundled services.
4. Per the STC, if SFHP's CEDT Assessor assessed a beneficiary and determines that he or she is eligible for CBAS services and SFHP or CBAS Center determines that there is insufficient CBAS center capacity in the area, SFHP authorizes Unbundled CBAS services and facilitate utilization through care coordination.
5. The following are Unbundled CBAS Core Services that may be authorized:
    a. Professional Nursing Services
    b. Personal Care Services
    c. Social Services
    d. Therapeutic Activities
        i. PT Maintenance Program
        ii. OT Maintenance Program
    e. Nutrition/Registered Dietitian/Meal

6. The following are Unbundled CBAS Additional Services that may be authorized:
    a. Physical Therapy
    b. Occupational Therapy
    c. Speech and Language Pathology Services
    d. Mental Health Services
    e. CBAS Transportation
    f. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS Unbundled service Provider and Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services.

XV. Duplicative Services

Members residing in a long-term care facility may not access CBAS services. The goal of CBAS is to prevent or delay the use of necessary institutionalization. The services rendered by a CBAS Center would be duplicative of those rendered by the LTC Facility.

XVI. Dispute/Complaint Processes

Authorization Disputes

SFHP's Appeal process is designed to resolve provider and member disagreements of adverse authorization determinations. For Appeal processing instructions, refer to SFHP's Member Handbook, SFHP's Provider Manual, or SFHP Customer Service at **1(415) 547-7800.**

Claim Disputes

SFHP's Provider Dispute Resolution (PDR) process is designed to resolve provide dissatisfactions with SFHP's processing or payment of a claim, resubmission of a claim, or a claim adjustment. For PDR processing instructions, refer to SFHP's Claims Operation Guide or SFHP Customer Service at **1(415) 547-7800.**

Member Complaints

SFHP's Grievance process is designed to resolve member concerns in a manner that is accessible, timely and thorough. If a member wants to file a complaint or grievance, providers may help them. For Grievance processing instructions, refer to the SFHP's Member Handbook, SFHP's Provider Manual, or SFHP Customer Service at **1(415) 547-7800.**

XVII. Definitions

CBAS: Community-Based Adult Services

CEDT tool: Community Based Adult Services (CBAS) Eligibility Determination Tool. The tool assesses a SFHP member's level of medical and psycho-social needs. The outcome is used to develop intervention, care, and treatment plans.

CEDT Assessor: The Assessor, contracted by San Francisco Health Plan to conduct the initial assessments using the CEDT tool and reassessments Member's IPC, including any supporting documentation supplied by the CBAS Provider.

ERS: Emergency Remote Services

DAAS: Department of Aging and Adult Services

DHCS: Department of Health Care Services

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

F2F: the face-to-face CEDT assessment of a member to determine eligibility for CBAS services

H&P: History and physical (clinical documentation)

IOA: Institute on Aging; responsible for conducting the CEDT assessments.

IPC: Individual Plan of Care

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

SFHP: San Francisco Health Plan

XVIII. Staff Contact or Center Change Requests

Contact Provider Relations at **providerrelations@sfhp.org,** to change a contact at the CBAS Center for the following roles:

- Email list for CBAS conference calls
- CBAS contact for secure folders
- Banking changes

XIX. References

- California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions

Revision History

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