SAN FRANCISCO HEALTH PLAN

CO-71: Community-Based Adult Services

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	8/11/2026	New Policy
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	7/30/2026	

SFHP POLICY AND PROCEDURE

Community-Based Adult Services (CBAS)

Policy and Procedure Number:	CO-71
Department:	Utilization Management
Accountable Lead:	Clinical Operations Policy Analyst
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☐SFHP Care Plus (HMO D-SNP) ☐Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) administers Community-Based Adult Services (CBAS) to eligible Medi-Cal members to restore optimal capacity for self-care and prevent premature or unnecessary institutionalization.

SFHP ensures CBAS is consistent with the California Department of Health Care Services (DHCS) requirements, Medi-Cal 1115 Waiver provisions, and California Department of Aging (CDA) CBAS certification standards.

SFHP is responsible for all administrative aspects of CBAS. All prior authorization requests for CBAS, regardless of member's medical group assignment, are reviewed by SFHP and its Contracted Vendor, Institute on Aging (IOA).

This policy establishes the standards and procedures for CBAS authorization, care coordination, provider requirements, and oversight. All sections within this policy apply to SFHP's Medi-Cal business line unless otherwise specified.

PROCEDURE

SFHP ensures members requesting CBAS receive an initial eligibility assessment and biannual reassessment, every six (6) months in accordance with DHCS contractual requirements.

SFHP contracts with the Institute on Aging (IOA) to have a registered nurse, hereafter referred as "CEDT Assessor", who is responsible for conducting all eligibility

assessments utilizing the DHCS-approved CBAS Eligibility Determination Tool (CEDT). SFHP ensures that designated CEDT Assessor staff conduct eligibility assessments and receive the required training on the CEDT tool.

The following procedures govern the administration of CBAS.

I. CBAS Referral

A. The CBAS benefit is available to eligible Medi-Cal members aged eighteen (18) years or older.
B. A requestor must contact the CEDT Assessor to initiate a referral. A CBAS Referral Form must be submitted to the CEDT Assessor before any assessments or services are provided by a CBAS Center, and prior to submission of a CBAS Prior Authorization Request Form.
C. The referral must include the following:
    1. Member identifiers (name, date of birth, and SFHP ID number),
    2. Specific reasons for the CBAS request,
    3. Member's supporting medical history and physical information (H&P) from referring provider; and
    4. Member's prescription medications, if any.
D. The CEDT Assessor must send the referral form to SFHP.

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

A face-to-face (F2F) CEDT assessment of a member to determine eligibility for CBAS must be performed by the CEDT assessor. All F2F CEDT assessments must be performed by the CEDT assessor in person, not telephonic or via video call, with the member.

A. Upon receipt of a ***standard*** (five calendar day)[12] CBAS evaluation request, the CEDT Assessor will send a written acknowledgement of the request to the requestor and member.
B. The CEDT Assessor will make the first telephonic attempt to schedule the member's F2F assessment within five (5) calendar days of the request.
C. **Unreachable Members**:
    1. If the member or their representative cannot be reached during the initial attempt, the CEDT Assessor will conduct two (2) additional telephonic attempts between calendar days five (5) and eight (8) of the request.
    2. If the member remains unreachable, the CEDT Assessor will make a final attempt in writing allowing the member until calendar day fourteen (14) to schedule an assessment appointment. If the member does not schedule an appointment within fourteen (14) calendar days from the date of request, the CEDT Assessor will advise the member and the requestor, in writing, that a new request will be required if CBAS services are still needed.
D. For members successfully contacted, the F2F assessment appointment will be scheduled within fourteen (14) calendar days from the date the initial request was received.

E. The CEDT Assessor must complete the eligibility assessment using the DHCS approved CBAS CEDT within thirty (30) calendar days of the initial request.
F. Upon completion of the initial F2F eligibility assessment, the CEDT Assessor forwards the completed CEDT to the CBAS Center within one business day of eligibility decision.
    1. If the CEDT Assessor recommends CBAS eligibility approval, they will notify the CBAS Center to conduct the three (3) day individualized Plan of Care (IPC) assessment.
    2. 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 the reason for denial.

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

A. SFHP offers an ***expedited*** (up to 72 hours)[12] assessment process to determine CBAS eligibility when informed the member is in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or for members identified as being at high risk for SNF admission.
B. Hospital or Nursing facility staff that identified a potential need for expedited CBAS may submit a request directly to a SFHP Utilization Management (UM) Nurse for review. If the hospital or nursing facility staff have already referred to the CBAS Center, the Center must submit authorization request form, and all supporting clinical documentation from the discharging facility directly to the SFHP UM Nurse for review.
C. The F2F assessment may be waived if an SFHP UM nurse or Medical Director determines through another process (i.e., clinical information review), that the member is clinically eligible and in need of CBAS to be expedited.
    1. The CEDT Assessor does not conduct the initial expedited review. Instead, SFHP completes the clinical review and issues an eligibility recommendation within the expedited timeframe.
D. Upon completion of the clinical review, the SFHP UM Nurse will forward the completed eligibility assessment to the CBAS Center within one (1) business day of decision.
    1. If the SFHP UM Nurse recommends CBAS eligibility approval, they will notify the CBAS Center to conduct the three (3) day IPC assessment.
        i. SFHP reserves the right to request an F2F eligibility assessment if a need is identified.
    2. If the SFHP UM Nurse recommends CBAS eligibility denial, the clinical review and supporting documentation are forwarded to SFHP's Medical Director or physician designee for determination. If the decision is made to deny, a NOA denial letter including grievance

and appeal rights is sent to the member, the provider, and requesting provider (hospital/SNF/CBAS Center) explaining the reason for denial.

IV. Individualized Plan of Care (IPC)

A. Upon notification of eligibility approval, the CBAS Center's multi-disciplinary team must conduct a three (3) day assessment. Upon completion of the three (3) day assessment, the team will have developed a member's IPC.

B. The IPC will include the following:
   1. Anticipated Level of Service (LOS)
   2. Medical diagnoses and prescribed medications
   3. Planned frequency of individual services linked to individual objectives, therapeutic goals, and duration of service(s)
   4. An individualized activity plan designed to meet the needs of the member for social and therapeutic recreational activities
   5. Transportation needs
   6. Special diet requirements, dietary counseling and education
   7. If needed, a plan for any other necessary services that the CBAS center will coordinate

C. IPCs must be reviewed and updated at least every six (6) months by the CBAS staff, the member, and their support team. This review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

D. The CBAS Center must then electronically submit all necessary information required to make a medical necessity determination to CEDT Assessor for review. Necessary information includes:
   1. IPC (must include LOS)
   2. Clinical Documentation
   3. Prior Authorization Request using the CBAS Prior Authorization Request Form.
   4. Indication of Request Priority-Expedited or Standard

E. This electronic submission begins the formal Prior Authorization Request process.

V. Prior Authorization Requests

A. **CEDT Assessor's Role**
   1. The CBAS Center's electronic submission to the CEDT Assessor initiates the formal Prior Authorization Request process. The requested authorization priority (standardized/expedited) initiates the standard or expedited decision-making time frame in alignment with CO-22: Authorization Requests and Decision Timeframes.
   2. If the CBAS Center's electronic submission includes all necessary information to make a medical necessity determination, the CEDT Assessor reviews and provides authorization recommendations to SFHP within one (1) business day for expedited request or within three (3) business days for standard requests.

3. The CEDT Assessor must also ensure that the updated CEDT, including the date of the reassessment, is submitted as part of the authorization recommendation.
4. If the CBAS Center's electronic submission does not include the necessary information, the CEDT Assessor will notify the SFHP's CBAS contact via email within one (1) business day.
   SFHP's Long-Term Care (LTC)Team:
   i. **Fax:** 415-943-9700
   ii. **Direct Phone:** 415-615-4530
   iii. **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 seven (7) 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 1367.01.

B. **SFHPs Role**
1. The CEDT Assessor submits all authorization recommendations to SFHP via fax.
2. SFHP's Long Term Care nurse team reviews the CEDT Assessor's recommendation and approves as is or if there is a recommendation for modification or denial, SFHP's LTC Nurse forwards the completed CEDT and supporting documentation to SFHP physician reviewer for IPC-LOS review and determination.

C. **Prior Authorization Outcomes**
All authorization decision timeframes begin when the CBAS Center submits IPC-LOS authorization request to the CEDT Assessor. The CEDT Assessor and SFHP share the standard or expedited decision-making timeframe as indicated above in Section V(A) Prior Authorization Requests.
1. **Approval.** If the CEDT Assessor recommends approval, SFHP issues an approval letter to the member, the provider, and the CBAS Center within seven (7) calendar days for ***standard*** requests or within seventy-two (72) hours for ***expedited*** requests.
   i. Approved IPC-LOS authorizations are created with a twelve (12) month effective period.
      1. CEDT Assessor continues to perform the required biannual eligibility reassessment, every six (6) months (See Section VI. Eligibility Reassessments and Reauthorization Process).
      2. Notification to SFHP after the reassessment is only required if CEDT Assessor recommends IPC-LOS reduction, increase, or eligibility denial.
2. **Insufficient Information.** If the 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 fourteenth (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 fourteen (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, the 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 in alignment with CO-01: Utilization Management (UM) Decision Letters.

3. **Partial Denial or Denial**. 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 will be provided to the CEDT Assessor within twenty-four (24) hours of the decision.
   - **ii.** SFHP will notify the member, the provider, and the CBAS Center of the partial denial or denial via the NOA letter within seven (7) calendar days for ***standard*** requests or within seventy-two (72) hours for ***expedited*** requests.
     If partial denial or denial is determined by SFHP's physician reviewer, the 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 in alignment with CO-01: Utilization Management (UM) Decision Letters.

VI. Eligibility Reassessments and Reauthorization Process

A. To continue receiving CBAS, members previously deemed eligible (during initial F2F assessment) will receive biannual reassessments [every six (6) months] or up to every 12 months when determined by SFHP Long Term Care nurse to be clinically appropriate in accordance with DHCS contractual requirements.
B. Eligibility reassessments are completed by the CEDT Assessor using the member's updated IPC-LOS submitted by the CBAS provider and the DHCS approved CEDT.
C. The CEDT Assessor must also ensure that the updated CEDT, including the date of the reassessment, is submitted as part of the authorization recommendation.
D. The CBAS Center must submit a request to begin the CBAS reassessment process. Reassessments are required when:
   1. Mandatory biannual reassessment date is approaching [every six (6) months]

2. Annual prior authorization end date is approaching; or
3. Due to a change in status that would require a change in the member's IPC-LOS

E. The CBAS Center must send a new Prior Authorization Request form, including the updated IPC-LOS, to the CEDT Assessor. The CBAS Center must indicate any changes of status, increases or decreases in days, additional medical information, etc.
   1. If the member is already receiving CBAS and the CBAS Center requests that services remain at the same level, the CEDT Assessor may conduct the reassessment using the member's IPC-LOS documentation supplied by the CBAS Provider and no F2F review is required if the IPC-LOS and medical records are current and dated within the year.
   2. If there is an increase due to a change in level of need, or denial, deferral, or reduction (partial denial) in the requested level of CBAS for a member, a F2F review must be performed by the CEDT Assessor using the DHCS approved CEDT.
   3. 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 CEDT.

F. Th CEDT Assessor shall not recommend partial denial or denial of requested CBAS without completing a F2F review, using the CEDT.

G. The CEDT Assessor must provide all authorization recommendations through SFHP's existing prior authorization process as outlined above under Section V. Prior Authorization Requests. The CEDT Assessor must also ensure that the updated CEDT, including the date of the reassessment, is submitted as part of the authorization recommendation.

VII. Emergency Remote Services (ERS)

CBAS ERS is in compliance with the California Department of Aging (CDA) All-Center Letter, ACL 22-04, Launch of New CBAS Emergency Remote Services (ERS). ERS is the temporary provision and reimbursement of CBAS in alternative service locations and/or via telehealth, including telephone or virtual video conferencing, as clinically appropriate during specified emergencies. ERS allows 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).

SFHP, CBAS Centers, and CEDT Assessor utilizes the Peach Provider Portal for ERS correspondence, form submission, and authorizations as required by the CDA. CBAS Centers are responsible for closing ERS statuses as needed and completing all required follow-up actions.

A. **ERS Eligibility**
Current CBAS participants are eligible for ERS and must have the following documentation in place:
1. Approved IPC-LOS and Authorization.
2. Signed CBAS Participation Agreement.

B. **Circumstances for ERS**
SFHP provides ERS under the following circumstances:
1. Participant is experiencing a Public Emergency such as a state or local disaster, regardless of whether formally declared. Such emergencies 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 time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict members enrolled in CBAS from receiving CBAS in-person at the CBAS provider location, subject to approval by SFHP. Specific personal emergencies may include serious illness or injury*, crises**, care transitions such as to/from nursing facility, hospital, home*** meeting the following definitions:
    - **i.** *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.
    - **ii.** **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.
    - **iii.** ***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.

C. **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:
    - **i.** 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.

ii. Hospitalization – whether the participant 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 participant's primary/personal health care provider due to recent illness or injury.

iv. Participant's overall health condition

v. Extent to which other services or supports meet the participant's needs during the emergency.

vi. Personal crises such as sudden loss of caregiver or housing that threaten the participant's health, safety, and welfare.

D. **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:
    - **i.** Regular communication with the participant, including the following performed by a center multidisciplinary team member at least weekly during provision of ERS:
        1. Review and update of the ERS participant's health and functional status based on emerging needs.
        2. Review of the care plan for ERS and adjustments made as indicated.
    - **ii.** Phone and email access for participant and family support six (6) hours daily, Monday through Friday.
    - **iii.** Assessment of participants' and caregivers' current and emerging needs
    - **iv.** Response to needs through targeted interventions
    - **v.** Communication and coordination with participants' networks of care supports
    - **vi.** Identification of equipment/technology needs and assistance with telehealth
    - **vii.** Delivery of services and visits in-person if barriers to telehealth exist
    - **viii.** Delivery of/arranging for delivery of food, medications, and/or supplies. Meal delivery limited to no more than two (2) meals per day.

E. **Timeframe for Provision of ERS to a Participant**

1. Provision of ERS supports and services is temporary and time limited.
    - **i.** Short Term: Participants may receive ERS for an emergency occurrence for up to three consecutive months.
    - **ii.** Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three (3) 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.

iii. ERS End Date: An ERS incident ends when:

1. The precipitating emergency is resolved and the participant can return to the center to receive care plan services and supports.
2. CEDT Assessor recommends and SFHP's Medical Director determines ERS is no longer appropriate and/or that the participant requires alternative supports and services.
3. The participant's existing CBAS authorization expires without reauthorization.

F. **Initiation of ERS**

1. 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:
   - **i.** Participant's status relative to their existing person-centered plan at time of emergency;
   - **ii.** Participant's need for specific supports and services at time of emergency; and
   - **iii.** Whether the CBAS provider can meet the participant's needs and/or if additional services and supports are needed.
     1. 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.
2. 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.
3. CBAS Center completes the CEIF (CDA 4000), which includes:
   - **i.** Date of emergency and date of participant/caregiver consent for ERS;
   - **ii.** Nature of emergency; and
   - **iii.** Participant's identified needs and ERS care plan that addresses supports and service needs and demonstrate that the participant meets ERS criteria.
4. CBAS Center completes the CBAS Prior Authorization Request Form.
   - **i.** Selection of ERS
   - **ii.** Requested ERS duration [not to exceed three (3) consecutive months]

G. **Initial Authorization of ERS**

1. Within three (3) working days after the start of ERS, CBAS Center sends a copy of completed CEIF (CDA 4000) and CBAS Prior Authorization Request Form to CEDT Assessor for review.
    - **i.** 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*** five (5) business days or ***expedited*** seventy-two (72) hours decision-making timeframe
3. CEDT Assessor provides ERS authorization determination recommendations to SFHP.
    - **i.** If the CEDT Assessor recommends approval, SFHP issues an approval letter to the member, the provider, and the CBAS Center.
    - **ii.** 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 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 (3) month ERS period.

H. **Reauthorization of ERS**

1. ERS for an emergency occurrence may not exceed three (3) 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 (3) months, an updated IPC, CEIF (CDA 4000), and CBAS Prior Authorization Request Form is required.
3. Completed forms must be submitted to CEDT Assessor at least one (1) week prior to expiration of the existing ERS approved end date.
    - **i.** 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 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*** five (5) business days or ***expedited*** seventy-two (72) hours decision-making timeframe

5. The CEDT Assessor must provide ERS authorization determination recommendation to SFHP. Refer to Section VIII Emergency Remote Services (ERS) subsection G.

I. **Electronic Visit Verification (EVV) Requirements**

1. When ERS is delivered in the participant's home, CBAS providers are subject to EVV requirements. EVV is a telephone and computer-based solution that electronically verifies in-home service visits occur.
2. 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.
3. SFHP must demonstrate compliance with EVV System requirements for personal care services and home health services.

VIII. CBAS Services

CBAS benefits include the following:

A. **Core Services**

1. Professional nursing services provided by a registered nurse (RN) or licensed vocational nurse (LVN), which includes one or more of the following, consistent with scope of practice: observation, assessment, and 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 skinned nursing care and interventions.
2. 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.
3. Social services provided by social work staff, which includes one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination
4. Therapeutic activities organized by the CBAS center activity coordinator, which includes group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS members 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.
5. 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.

B. **Additional Services**

The following additional services will be provided to all eligible CBAS member as needed and as specified on the member's IPC.

1. Restorative physical, occupational, and speech 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, physical and 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 multi-disciplinary team."
2. 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.
3. Registered dietician services provided a registered dietician for the purpose of assisting the CBAS member and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.
4. Transportation, provided or arranged, to and from the CBAS member'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

A. **Transfer from another CBAS Center**

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

1. If the member requests to transfer to another CBAS Center and is still within their current CBAS Center's twelve (12) month authorization period, a F2F reassessment may not be required.
    - **i.** To determine when F2F reassessments are required, refer to above section VI. Eligibility Reassessments and Reauthorization Process section D, E, F.
2. 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.
3. CBAS Center is to select "Transfer from CBAS Center" on the SFHP/CBAS Prior Authorization Request form.

4. The transfer request must include a new IPC-LOS completed by the CBAS Center the member is transferring to.
5. The CEDT Assessor reviews the transfer request and provides authorization determination recommendations to SFHP within one (1) business day for expedited requests or within two (2) business days for standard requests.
6. SFHP generates an authorization for the receiving CBAS Center. SFHP follows the authorization process outlined above in Section V. Prior Authorization Requests.

B. **Member Transfer from Medi-Cal Fee-for-Service (FFS), Kaiser, or Anthem Blue Cross (ABC)**
   1. SFHP and CBAS Centers must collaborate to ensure uninterrupted access to appropriate CBAS for members switching from Medi-Cal FFS, Kaiser, or Anthem Blue Cross (ABC).
   2. SFHP honors CBAS eligibility determinations previously established by Medi-Cal FFS, Kaiser, or ABC. To facilitate this, the CBAS Center must provide the following documentation from the prior payer if available:
      - **i.** Approved CBAS Eligibility Determination Tool (CEDT)
      - **ii.** Completed IPC and LOS
      - **iii.** Approved Treatment Authorization Request (TAR)
   3. If the approved CEDT assessment is not available, the CBAS Center must submit the approved TAR form from Medi-Cal FFS, Kaiser, or ABC to verify eligibility.
   4. The effective date for CBAS under SFHP must coincide with the member's SFHP enrollment date
   5. To facilitate the process, the CBAS Centers must submit a request to the CEDT Assessor using the CBAS Prior Authorization Request Form
   6. The CBAS Center must select the checkbox labeled "Transfer from Anthem Blue Cross, Kaiser, or Medi-Cal FFS" on the Prior Authorization Request form
   7. The CEDT Assessor reviews the transfer request and provides authorization recommendations to SFHP within one (1) business day for ***expedited*** requests or two (2) calendar days for ***standard*** requests
   8. Following the receipt of the CEDT Assessor's authorization determination recommendation, SFHP generates the authorization for the CBAS Center in accordance with Section V. Prior Authorization Requests.

XI. Respective Authorizations

A. CBAS services require prior authorization. SFHP applies its retrospective authorization policy as detailed in CO-22: Authorization Requests and Decision Timeframes.
B. Retrospective requests must be submitted no later than thirty (30) calendar days after the date of service AND must meet one of the conditions below.

Authorization requests received later than thirty (30) calendar days after the date of service are denied

C. 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 (2) separate authorizations.
D. Retrospective authorization requests are only considered under the following conditions:
    1. Member receives retrospective eligibility;
    2. Certification of the Medi-Cal beneficiary's eligibility by the county welfare department was delayed;
    3. Member does not identify himself/herself to the provider as a SFHP member by deliberate concealment, or because of physical or mental incapacity;
    4. Non-emergency medical transportation;
    5. DME and medical supplies delaying hospital discharge;
    6. Professional fees for radiology and pathology, received retrospectively, and connected with an approved service; or
    7. 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).
E. For retrospective authorization requests, the decision is made within thirty (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 thirty (30) calendar days of receipt of the request.

XII. Lapsed CBAS Authorizations

A. When the SFHP member is away from the CBAS Center (not attending their previously scheduled days) for three (3) months or longer, the Prior Authorization may lapse or expire.
B. If the member has not yet returned to the CBAS Center, the CBAS Center will not be able to obtain reauthorization from SFHP.
C. If and when the member returns to the CBAS Center and the SFHP Prior Authorization expired more than three (3) 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.
D. 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

A. CBAS Centers are required to complete CBAS Discharge Plans for members 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.
B. Discharge plan must include the following:
    1. The Member's name and ID number
    2. The name(s) of the Member's physician(s)
    3. Date the member received notice of pending discharge
    4. Date the CBAS benefit will be terminated
    5. Specific information about the Member's current medical condition, treatments, and medications
    6. 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
    7. A statement on how Enhanced Case Management services will be provided to the Member if eligible for these services
    8. Signature from the member or the member's representative and the date signed (if attainable)
    9. Upon discharge plan completion, CBAS Center will provide copies of the member's discharge plan to:
        i. The member; and
        ii. SFHP via upload to the secure SFHP FTP site, "Miscellaneous" folder, using the nomenclature, "mmddyyyy [Member SHFPID]dischargeplan.pdf".

XIV. Unbundled Services

A. 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.
B. 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").

C. 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.
D. 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.
E. The following are Unbundled CBAS Core Services that may be authorized:
    1. Professional Nursing Services
    2. Personal Care Services
    3. Social Services
    4. Therapeutic Activities
    5. PT Maintenance Program
    6. OT Maintenance Program
    7. Nutrition/Registered Dietitian/Meal
F. The following are Unbundled CBAS Additional Services that may be authorized:
    1. Physical Therapy
    2. Occupational Therapy
    3. Speech and Language Pathology Services
    4. Mental Health Services
    5. CBAS Transportation
    6. 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.

MONITORING

A. Monthly, the utilization management (UM) workgroup monitors authorization and appeal metrics, clinical member grievance (including Independent Medical Reviews, State Fair Hearings, and Consumer Complaints) trends, as well as service utilization trends. The UM workgroup submits reports to the Utilization Management Committee (UMC) and Quality Improvement and Health Equity Committee (QIHEC) for oversight, input, and strategic direction. Collaboratively, the committees make recommendations for corrective action and/or identify where UM processes can be revised, if necessary, to improve member experience, address barriers, and ensure

the UM criteria are consistent with current industry and evidence-based practices and state/federal regulations

B. Quarterly, the Clinical Operations Nurse Trainer Auditor conducts an internal audit of authorization files including adverse and favorable determinations. The purpose of the internal audit is to ensure authorization files meet the statutory/regulatory requirements of CMS/DHCS/DMHC as well as accreditation guidelines of NCQA. The audit follows NCQA's 8/30 audit sample methodology.

C. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18 and the PPC process defined in QI-19.

D. SFHP Compliance and Utilization Management's LTC team submits all required CBAS reports to DHCS 30 calendar days following the end of each reporting period and in the format specified by DHCS. The required reports include the following:
    a. On a quarterly basis, the number of members assessed for CBAS and the total number of members receiving CBAS, including bundled and unbundled services put together by Compliance and Regulatory Affairs (CRA), Institute of Aging (IOA), and Grievances and Appeals (G&A).
    b. On a quarterly basis, identification of additions and deletions of CBAS Providers, and notification to DHCS when network capacity decreases by 5% or more, as required in Exhibit A, Attachment III, Subsection 5.2.13.C (Network Reports)
    c. On a quarterly basis, a summary of complaints related to the provision of CBAS services, appeals reporting, grievance reporting, and call center complaints reporting put together by CRA, IOA, and G&A.
    d. On an annual basis, a list of its contracted CBAS Providers and its CBAS accessibility standards put together by CRA and Provider Network Management (PNM).

E. SFHP's LTC team ensures the CEDT Assessor complies with the required timeframes for face-to-face (F2F) eligibility assessments through adjudication of a monthly tracking sheet that outlines workflow and includes month-over-month reconciliation.

DEFINITIONS

Community Based Adult Services (CBAS): Community-Based Adult Services means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set form in the CalAIM Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

CBAS Eligibility Determination Tool (CEDT): means a tool that assesses a SFHP member's level of medical and psychosocial 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 Individualized Plan of Care, including any supporting documentation supplied by the CBAS provider.

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

CBAS Emergency Remote Services (ERS): Emergency Remote Services means the following services, provided in alternative Service Locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

DAAS: Department of Aging and Adult Services.

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

Face-to-Face (F2F): means a CEDT assessment of a member to determine eligibility for CBAS. All F2F CEDT assessments must be performed by the CEDT assessor in person, not telephonic or via video call, with the member.

H&P: History and physical (clinical documentation)

Institute On Aging (IOA): SFHP's contracted CEDT Assessor and is responsible for conducting the CEDT Assessments.

CBAS Individual Plan of Care (IPC): means a written plan of care developed by a CBAS center's multidisciplinary team, as specified in the CalAIM Terms and Conditions, or as specified in any subsequent demonstration amendment, or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

CBAS Discharge Plan of Care: means a discharge plan of care based on the Member's CBAS assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

Member: an individual that is enrolled in the SFHP Medi-Cal line of business.

AFFECTED DEPARTMENTS/PARTIES

Health Services – Care Management
Health Services – Utilization Management
Compliance & Regulatory Affairs – Delegation Oversight
Operations – Claims
Operations – Member Services
Operations – Member Eligibility Management
Operation – Provider Network Management

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

1. CO-01: Utilization Management (UM) Decision Letters
2. CO-22: Authorization Requests and Decision Timeframes
3. GA-01: Clinical Member Grievances
4. GA-04: Member Appeals
5. QI-18: Potential Quality Issues
6. QI-19: Provider Preventable Conditions

REVISION HISTORY

Original Date of Issue:	October 1, 2012
Revision Approval Date(s):	April 18, 2024; October 10, 2014; October 1, 2016; October 29, 2019; September 1, 2022; December 1, 2022; January 13, 2023; February 23, 2024; February 5, 2025; July 23, 2026

REFERENCES

1. Code of Federal Regulations, Title 42, Section 438.406 (b)3, 438.420
2. California Code of Regulations, Title 22, Section §53858, §53893, §51014
3. California Code of Regulations, Title 22, Section §54213, §78345, and §78437
4. California Health and Safety Code, Sections 1367.01, 1367.27, 1368, 1368.01, 1368.02, 1368.03, 1368.04, 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.35, 1374.36, and 1570.7(n)
5. DHCS APL 21-011: Grievance and Appeals Requirements, Notice and “Your Rights” Templates
6. Welfare and Institution Code, Sections 141.84.201(d)(4) and 14184.102(d) 14525, 14526.1
7. Welfare and Institutions Code 10961

8. Code of Federal Regulations, Title 42, Section 438.406 (b)
9. DHCS All Plan Letter 20-017: Requirements for Reporting Managed Care Program Data
10. DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023
11. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-06 Initiation of CBAS Emergency Remote Services (ERS). Amended October 3, 2023.
12. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-04 Launch of New CBAS Emergency Remote Services (ERS). August 8, 2022.
13. Centers for Medicare and Medicaid Services (CMS) California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions (STC). Amended November 28, 2014.
14. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 19-02 Implementation of New CBAS Individual Plan of Care (IPC). Amended March 19, 2019.
15. DHCS All Plan Letter 22-020: Community-Based Adult Services Emergency Remote Services. November 2, 2022.
16. CalAIM STCs Section V.A.21
17. DHCS/SFHP Contract, Exhibit A, Attachment III, Section 5.4 (Community Based Adult Services)