



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

September 18, 2012

Debra M. Cornez, Director
Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814-4339

Dear Ms. Cornez:

The Department of Health Care Services has designated a fair hearing decision in the matter of eligibility for Community-Based Adult Services (CBAS) as a Precedential Decision in accordance with Government Code Section 1142560(b).

Please find for publication in the next California Regulatory Notice Register the following documents:

- Public Notice
- The Precedential Decision
- The Index of Precedential Decisions

Should you have any questions in this matter, please call Mark Helmar at 916-296-1231.

Thank you for your prompt attention to this matter.

Sincerely,

Douglas Press
Deputy Director and Chief Counsel

cc: Charles DeCuir
Presiding Administrative Law Judge
California Department of Social Services



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

ACTION: Notice of Availability of Precedential Decisions and Decision Index
Government Code Section 11425.60(b)

SUBJECT: Eligibility for Community-Based Adult Services (CBAS), DHCS-12-001

PUBLIC NOTICE: NOTICE IS HEREBY GIVEN that the Department of Health Care Services (DHCS), pursuant to the requirements of section 11425.60 of the Government Code, has designated a precedential decision relating to the eligibility of Medi-Cal beneficiaries for Community-Based Adult Services (CBAS). This precedential decision affirms that the Department's Quality Assurance reviewers and 2nd Level reviewers have the authority to (1) review a nurse reviewer's initial assessment of CBAS eligibility and (2) disagree with that assessment in making the final decision about a person's eligibility for CBAS services.

NOTICE IS ALSO GIVEN that the Department maintains an index of precedential decisions. The public may access the index and text of the precedential decisions through the DHCS website <http://www.dhcs.ca.gov>. Additionally, the public may request copies of the index and precedential decisions by submitting a Public Records Act request to:

Ms. Jeannie Smalley, Chief
Monitoring and Oversight Section
Long-Term Care Division
Department of Health Care Services
MS 0018
P.O. Box 997413
Sacramento, CA 95899-7413

DEPARTMENT OF HEALTH CARE SERVICES

DHCS-12-001

Dated: 9/17/12

Toby Douglas
Director

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BEFORE THE
DEPARTMENT OF HEALTH CARE SERVICES
STATE OF CALIFORNIA

In the Matter of Eligibility for Community-
Based Adult Services (CBAS) for:

G.Y.L.

Claimant.

Hearing No. 2012058068

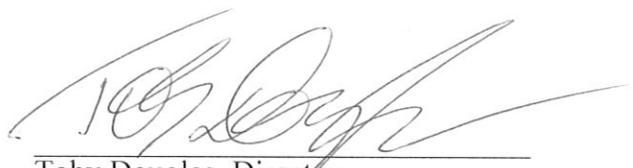
PRECEDENTIAL DECISION
No. 12-001

PRECEDENTIAL DECISION
(Government Code Section 11425.60(b))

The Department of Health Care Services hereby designates as precedential the entire Decision in the Matter of Eligibility for Community-Based Adult Services (CBAS) for G. Y. L. (State Hearing No. 2012058068).

This precedential decision shall become effective on September 17, 2012.

IT IS SO ORDERED September 17, 2012.



Toby Douglas, Director
DEPARTMENT OF HEALTH CARE SERVICES

SUMMARY

The Administrative Law Judge hearing this case determined that the Department of Health Care Services (DHCS) incorrectly denied the claimant Community-Based Adult Services (CBAS) under the *Darling v. Douglas* Settlement Agreement after a Department RN assessor conducted a face-to-face interview, reviewed the claimant's medical records, completed the CBAS Eligibility Determination Tool (CEDT), and found the claimant was eligible for CBAS benefits. The ALJ found that the Claimant is eligible because she was found eligible by a Nurse Assessor after a face-to-face interview and visit to her Adult Day Health Care (ADHC) center, a finding which was wrongly overturned by a Quality Assurance (QA) and Second Level Reviewer

However, the Director rejects the conclusion that the Department does not have the authority to review a nurse reviewer's initial assessment of CBAS eligibility and to disagree with that assessment in making the final decision about a person's eligibility for CBAS services.

The *Darling* settlement narrowed the bases of eligibility which had governed the ADHC program. The Settlement Agreement (SA) established five specific categories of eligibility. NF-A is a level of care standard that is in addition to the ADHC criteria specified in Welfare and Institutions Code section 14525. The Settlement Agreement restricted the ADLs and IADLs that applicants needed to have assistance or supervision with in order to qualify under the categories relating to mental illness, brain injury, or dementia. It also requires participants who are developmentally disabled to be regional center clients as a condition of CBAS eligibility. In addition to these eligibility categories, the Settlement Agreement explicitly requires that the ADHC medical necessity criteria, including the core services requirements in Section 14550.5, be applied to the CBAS program.

The Director finds that, while a fair hearing is the appropriate venue to resolve disputes about CBAS eligibility on medical necessity issues, it is not a forum to resolve disputes about the processes the Department uses in administering the CBAS program. These types of disputes are properly dealt with through the SA's Section XXI. Dispute Resolution Process.

FACTS

On February 7, 2012, the CA Department of Health Care Services (the Department) sent the claimant a notice of action informing her she was not eligible for Community-Based Adult Services (CBAS). On February 10, 2012, the claimant requested a state hearing to dispute the Department's action.

The state hearing was held on July 12, 2012. The claimant was present and was represented by an Authorized Representative from the Adult Day Health Care (ADHC) Center (the Center). The claimant, through her Authorized Representative, submitted her request for hearing, Authorized Representative form and a Statement of Position with attachments as evidence. The CA Department of Health Care Services was represented by a Department representative from the San Francisco Field Office, who also submitted a Statement of Position with attachments as evidence. All of the documentary and testimonial evidence proffered by both parties was considered in determining the findings of fact and rulings made in this decision.

The claimant's Authorized Representative stated the claimant wished to dispute the Department's action denying the claimant CBAS after the Department RN, who conducted the initial assessment and face-to-face interview, determined the claimant met the CBAS criteria and she wished to dispute the Department's determination she did not qualify for CBAS under Category B, also referred to as Category II.

It is undisputed the claimant is an 86 year-old monolingual Cantonese-speaking female, whose diagnoses include the following: hypertension, congestive heart failure, degenerative joint disease, chronic dizziness, depression, anxiety, paroxysmal atrial fibrillation, cardiomyopathy, osteoporosis, gastroesophageal reflux disease, cataract, and ascending cholangitis. It is also undisputed the claimant's medications include the following: Coreg, Norvasc, hydrocortisone cream 2.5%, aspirin, Protonix, Colace, Lisinopril, Claritin, and Actigall.

It is undisputed the claimant lives alone. She has been attending the ADHC center since March 2009 and she currently attends the ADHC center three days per week for about four hours per visit. The claimant eats at least one meal each time she attends the ADHC center.

It is undisputed the claimant currently receives 121.4 hours of In-Home Supportive Services (IHSS) per month. These services are provided by her son, who is her IHSS provider.

A copy of the notice of action granting the claimant IHSS was admitted into evidence. The claimant's Authorized Representative said the notice accurately reported the claimant's current IHSS benefits. A review of the document reveals the claimant is authorized to receive the following IHSS: six hours per month for domestic services, which includes cleaning the floors, washing kitchen counters, stoves, refrigerators, bathrooms, storing food, supplies, taking out the garbage, dusting, picking up, bringing in fuel; changing and making the bed and other miscellaneous tasks; six hours per week for meal preparation; one hour per week for meal clean-up; one hour per week for the routine laundry task; one hour per week for shopping for food; half an hour per week for other shopping errands, 4.67 hours per week for bowel and bladder care; 2.33 hours per week with assistance with dressing; 2.92 hours per week with assistance with ambulation; 1.4 hours per week with assistance with getting in/out of bed; 4.06 hours per week with assistance with bathing, oral hygiene and grooming; 1.17 hours per week with assistance with skin rubbing and repositioning; 1.17 hours per week of assistance with the claimant's medications; and .46 hours per week with accompaniment to medical appointments. Further review reveals the total hours of need were 125.9 hours per month, reduced to 121.4 hours per month by regulation.

The Department's representative testified that a Registered Nurse (RN) from the Department visited the ADHC center on January 14, 2012, to assess the claimant's eligibility for CBAS. She said the assessing RN conducted a face-to-face interview with the claimant and reviewed the medical records maintained on the claimant by the ADHC center. She said the claimant's medical records included the Individual Plan of Care (IPC) prepared and approved by the medical staff at the ADHC center. The IPC listed the claimant's abilities and needs for assistance and medical care.

The Department's representative stated that as part of the initial assessment, the assessing RN was required to complete the CBAS Eligibility Determination Tool (CEDT), containing information extracted from the ADHC center's medical records and the assessing RN's recommendation on whether the claimant met the criteria for CBAS. She said in the claimant's case, the assessing RN made the recommendation that the claimant met the criteria for CBAS and recorded her findings on the CEDT.

The Department's representative testified the claimant's CEDT was then reviewed by a Quality Assurance (QA) team consisting of at least two RNs, who checked it for inconsistencies and evaluated whether the assessing RN's findings were correct. She said the QA team determined the assessment by the RN who conducted the face-to-face interview was in error because the claimant did not meet all of the criteria in any one of the five CBAS categories. She said the

notice of action informing the claimant CBAS was denied was sent based on the determination made by the QA team.

A copy of the claimant's CEDT prepared by the Department's initial RN assessor was moved into evidence. A review of the document revealed it was signed by the assessing RN on January 11, 2012, and the RN checked the box indicating the claimant met the criteria for CBAS. Further review reveals that under the section titled "QA Reviewer," the box indicating "Disagree" is checked and the disagreement reason listed was as follows: "0 substantial nursing interventions to substantiate CBAS." Finally, the review reveals under the section titled "2nd Level Reviewer," the box indicating the individual does not meet the criteria for CBAS was checked. Both the "QA Reviewer" and the "2nd Level Reviewer" signatures were dated January 14, 2012.

The Department's representative testified the QA review is a business practice of the San Francisco Field Office. She said each QA team is composed of at least two RN evaluators, who review the initial assessment made by the RN, who conducted the face to face interview and reviewed the claimant's medical records at the ADHC center, including the IPC. She said the QA team is composed of RNs, who have more experience in the field of nursing and who can also look at what previous Treatment Authorization Requests (TARs) have been submitted on the claimant. She said every TAR that is submitted to the San Francisco Field Office is subject to a QA review to ensure quality control and to make sure the initial RN evaluator is following the CBAS program parameters.

The Department's representative testified the claimant met the CBAS eligibility diagnostic requirement for Category B/II because she has been diagnosed with chronic depression; however, she does not meet the medical necessity requirement set forth in sections 14525(c) and 14526.1(d)(1) of the CA. Welfare and Institutions Code. The Department's representative said section 14525(c) states the claimant must require ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition. She said section 14526.1(d)(1) states in part that the claimant must have one or more chronic or post-acute medical, cognitive, or mental health condition which requires monitoring, treatment or intervention without which the claimant's conditions will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization.

The Department's representative testified the Department reviewed the claimant's IPC prepared by the medical professionals at the ADHC center to determine whether the claimant's needs required ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of her medical, cognitive or mental health condition. She said the claimant's IPC listed five areas where professional nursing services are required; namely, a problem with her blood pressure; a problem with medication mismanagement; a problem with being at risk for fall/injury caused by impaired safety awareness, dizziness and a history of falling; a problem with pain in her neck, shoulders, low back and knees; and a problem with being underweight. She said the claimant's IPC also stated the claimant had expressed feelings of loneliness.

The Department's representative testified the treatments and/or interventions planned by the ADHC center to address the problems listed in the IPC could be handled by a non-professional such as the claimant's IHSS provider and did not require skilled nursing or medical professionals to perform them.

The Department's representative said the claimant's IPC indicated the claimant had a history of fluctuating blood pressure so the ADHC center staff has to monitor her vital signs and disease process and report abnormal changes to the claimant's primary physician and the family. She said the Department found no incidents of labile blood pressure and no admissions to the hospital for any blood pressure-related problems. She said the claimant's systolic blood pressure ranged from the 90's to 140's and her diastolic blood pressure ranged from 59 to 70. She said the claimant's medical records indicated the claimant's blood pressure was stable and was maintained on her current medication program. The Department's representative also testified skilled nursing care is not required for a person's blood pressure to be taken. She said the claimant's IHSS provider could be trained to take the claimant's blood pressure and report any changes to the claimant's doctor. She said the claimant is only at the ADHC center three days per week, so the claimant's family and IHSS provider should be trained to perform this task anyway.

The Department's representative said the claimant's IPC indicated the claimant mismanaged her medications, so the ADHC center staff was to instruct the claimant in the disease process, her medication regimen and administration, and to monitor the claimant for medication side-effects. She said the claimant's medications were not administered by the ADHC center, but instead were given to her and managed by her IHSS provider. She said it was not necessary for skilled nursing professionals to instruct the claimant about her medications or to monitor her for side effects. She said the claimant's pharmacist can instruct the claimant's family members, her IHSS provider, and the claimant on medication management and which side effects to look for, and the family and IHSS provider can report any changes to the claimant's primary physician.

The Department's representative testified the claimant's IPC indicated she was at risk for falling/injury because of impaired safety awareness, dizziness at times and she had a history of falling. She said the claimant has impaired bilateral lower extremity strength. She said to address this problem, the claimant's IPC indicated the professional nursing staff at the ADHC center would instruct the patient's family in safety measures to prevent falling and injury and supervise the patient in all her activities for safety. She said the ADHC center also provided individual and group exercises for the claimant. The Department's representative said professional nursing services and the services of a licensed therapist at the ADHC center are not required to instruct the claimant and her family about safety measures to prevent falling or to provide an exercise maintenance program. She said the instruction can be performed by the claimant's physician, who can also order range of motion and other exercises which can be done by the claimant at home with the assistance of her IHSS provider. She said the claimant is only at the ADHC center three days per week, and the needs to be monitored by her family or her IHSS provider. She testified that although the claimant's medical records indicated the claimant was seen by an emergency room physician on October 2011 and February 6, 2012, because she was nauseated and she fell, the fall apparently occurred at home, and it was the claimant's son who reported the incident and took the claimant for medical treatment, not the ADHC center. She said the claimant's family and IHSS provider can continue to monitor the claimant without the intervention of CBAS.

The Department's representative testified the claimant's IPC indicated the claimant has problems with pain in her neck, shoulders, low back and knees. She said to address the problem of pain, the claimant's IPC indicated the professional nursing staff at the ADHC center monitor and assess the complaints of pain, instruct the claimant in non-drug methods to reduce pain and to report any persistent pain to the claimant's family and primary care physician. The Department's representative said professional nursing services are not needed to address the patient's complaints of pain. She said the claimant's primary physician can instruct the

claimant, her family and her IHSS provider how to use non-drug methods to reduce pain, and the family and IHSS provider can report any persistent pain to the claimant's physician.

The Department's representative testified the claimant's IPC indicated the claimant is underweight and the professional nursing staff/registered dietician at the ADHC center should monitor the claimant's weekly weight, monitor her diet to ensure it is low in salt, fat and cholesterol, and should instruct the claimant to drink Ensure or snack between meals and to monitor that the claimant is drinking her Ensure. The Department's representative said the claimant's weight has not fluctuated during the last six months. She said the claimant is receiving IHSS for meal preparation and most of her meals are not eaten at the ADHC center. She said professional nursing services at the ADHC are not needed to weigh and monitor the claimant's diet because the claimant's IHSS provider or family members can be trained to perform these tasks.

The Department's representative testified the claimant's IPC reported she had expressed feeling of loneliness because she had no social outlet; she had limited access to community resources and social service support. She said the claimant's IPC indicated the ADHC center should monitor the claimant's emotional status and condition and provide social service support. The Department's representative testified the Department's review of the claimant's medical records indicated there had been no change in the claimant's mood or behavior which appears to have been stable. She said the claimant does not require professional nursing or social workers to provide relief from her isolation and depression. She said in lieu of CBAS services, the claimant could be referred to the Medi-Cal Enhanced Case Management (ECM) program. She said the claimant would then be assigned a caseworker, who would ensure she was referred to County Mental Health for treatment and to senior programs in the community where she could meet new friends and socialize with them on a regular basis and engage in exercise.

The Department's representative testified the Department also looked to see if there was any indication, as required by section 14526.1(d) of the CA Welfare and Institutions Code, that the claimant's health would likely deteriorate so that she would be at high risk of requiring emergency department visits, hospitalization, or other institutionalization if CBAS were not granted. She said the claimant's medical records indicate claimant is stable, and the professional nursing services, therapist services, and dietician services being provided by the ADHC center could be performed by the claimant's family and/or IHSS provider without causing her to deteriorate. She said it is the Department's position that the denial of CBAS will not cause the claimant's medical, cognitive, or mental health condition to deteriorate and place her at high risk of requiring emergency department visits, hospitalization, or institutionalization.

The claimant's Authorized Representative testified that she is the claimant's social worker at the ADHC center. She said the claimant disputes the ability of the Department to deny her CBAS benefits after the Department's RN, who conducted the face-to-face interview and who reviewed the claimant's medical records in detail when completing the CEDT, determined she was eligible for CBAS.

The claimant's Authorized Representative, who has a Master's degree in Social Work and who is the claimant's assigned social worker at the ADHC center, testified that the Department must look at the entire picture when deciding whether CBAS should be granted. She said the claimant is 86 years old and lives alone. She said the claimant only speaks Cantonese and is isolated from the community because of the language barrier. She said termination of the ADHC program has caused the claimant a lot of anxiety which has increased her depression. She said the claimant does not get along with her daughter-in-law, and she relies on the ADHC center social worker to mediate any problems. She said the claimant's mental health has

deteriorated from August 2011, when she had a GDE score of 5/15, to February 2012, when her GDE score was 7/15. She said the ADHC center had not yet reported the change to her physician because it was deemed not to have reached a level worth reporting yet.

The Authorized Representative said there is no one in the claimant's family who can assist her with her depression, other than her son, who works full time at a minimum wage job and who is often not available. She said the ADHC center tried to refer the claimant to County Mental Health for treatment for her depression, but her family won't allow it because of the stigmatization they believe it would cause. She said this has left the ADHC center as the only place where the claimant's depression can be treated.

The Authorized Representative testified the claimant only speaks Cantonese and because there are other Cantonese speaking individuals at the ADHC center, the claimant feels comfortable socializing at the center. She said because the claimant is not bilingual it is unlikely she could communicate with the other seniors at a senior center to form new friendships.

One of the RNs from the ADHC center also testified. She said even though claimant's blood pressure looks normal, she is at high risk for crisis because she has several medical problems which affect her heart. She said the claimant has hypertension, congestive heart failure, paroxysmal atrial fibrillation, and cardiomyopathy which place her at high risk for crisis and require monitoring by an RN. She said that the claimant also complains of dizziness and nausea which caused her fall in October 2011, so it too must be monitored.

The Authorized Representative testified the claimant has been a patient at the ADHC center since 2009 and has developed a high level of trust with the staff at the ADHC center. She said that because of this trust, the claimant will report her medical problems to staff instead of her family or her doctor and she relies on them to know whether the problem is serious or not. She said this ability to trust someone enough to discuss her physical problems would be lost if CBAS is not granted.

The Department's representative testified the Department realizes the claimant has multiple medical conditions that could affect her heart, but the claimant's condition is stable and she has not been treated for any heart related symptoms during the past six months. She said the claimant is only seen at the ADHC center three times per week, so they cannot monitor her all the time anyway. She said the claimant's family and her IHSS provider can monitor the claimant for any changes in her health and report those changes to the claimant's primary care physician. She said the Department realized the claimant was treated in the emergency room in October 2011; however, it was the claimant's son, who is her IHSS provider for almost 124 hours per week, who realized she had fallen and took her to the emergency room, not the ADHC center. She said there is no reason the claimant cannot be monitored at home.

The Department's representative said the Department understands the trust the claimant has developed for the staff at the ADHC is important; however, trust can and should be developed with the claimant's son and her physician and in time she should be able to develop trust in the staff at the senior centers. She said the claimant's trust in the ADHC center is not a sufficient reason to grant CBAS benefits and based on the claimant's medical problems and plan of treatment listed in her IPC, the claimant does not meet the CBAS eligibility requirements. She requested the Department's action denying the claimant CBAS be sustained.

LAW

All further references, unless otherwise noted, are from Title 22 of the California Code of Regulations (CCR). (§50005). For purposes of this decision, W&IC is the abbreviation for the Welfare & Institutions Code.

Applicants or beneficiaries shall have the right to a State hearing if dissatisfied with any action or inaction of the county department, the Department of Health Care Services or any person or organization acting in behalf of the county or the Department relating to Medi-Cal eligibility or benefits. (§50951(a))

Hearings are to be conducted in accordance with regulations and procedures set forth by the California Department of Social Services (CDSS). Those regulations are set forth in Division 22 of the Manual of Policies and Procedures (MPP) issued by the CDSS. (§50953)

The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing. Prior to taking evidence, the Administrative Law Judge shall identify the issues and shall state the order in which evidence shall be received. (MPP §22-050.1 and .11)

In administrative tribunals, the party asserting the affirmative of the issue generally has the burden of proof. (*Cornell v. Reilly* (1954) 127 Cal.App.2d 178, 273 P.2d 572; and California Administrative Agency Practice, California Continuing Education of the Bar (1970) p.183)

The burden of proof is the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evidence Code, §115.)

A "preponderance of the evidence" means "more likely than not." (*Tellabs, Inc. v. Makor Issues & Rights, Ltd.* (2007) 127 S.Ct. 2499, 2513, 168 L.E.2d 179, 196.)

In Home Support Services:

The term IHSS is often used to refer generally to three distinct state/county programs which provided in-home services to disabled populations. These programs are the following:

- PCSP (Personal Care Services Program) is a program funded through Medi-Cal and provides services to individuals who otherwise qualify for Medi-Cal and have a chronic disabling condition. Eligibility is fully based on Medi-Cal eligibility. PCSP is unavailable to individuals whose provider is their spouse or to minor individuals whose parent is the provider. It is also unavailable if the recipient is receiving advance payment or a restaurant meal allowance. See, generally, Welfare and Institutions Code 14132.95
- IHSS Plus Option (IPO) is a program funded through Medi-Cal which provides services for most federally eligible Medi-Cal recipients who do not qualify for the PCSP Program. Eligibility is fully based on Medi-Cal eligibility. See, generally, Welfare and Institutions Code section 14132.952.
- IHSS Residual (IHSS-R) is a program limited to disabled individuals who do not qualify for federal Medi-Cal program participation, primarily legal aliens. Eligibility is based on

linkage to the SSI/SSP program. See, generally, Welfare and Institutions Code sections 12300 et. seq.

Department of Health Care Services:

The DHCS is the single state agency approved by the Secretary of the Department of Health and Human Services to administer the Medi-Cal program. (§50004(a)) The DHCS shall administer the Medi-Cal program in accordance with the following: (1) The State Plan under Title XIX of the Social Security Act, (2) Applicable State law, as specified in the Welfare & Institutions Code, and (3) Medi-Cal regulations. (§50004(b))

The Director of the DHCS may develop an agreement with another agency to perform state hearings. The Department shall retain sole authority for decision-making on Medi-Cal issues. (§50953(c))

Adult Day Health Care:

"Adult day health care" (ADHC) means an organized day program of therapeutic, social, and health activities and services provided pursuant to this chapter to elderly persons with functional impairments, either physical or mental, for the purposes of restoring or maintaining optimal capacity for self-care. (§54013)

AHDC, as an optional Medi-Cal benefit, was eliminated in the California State Budget in 2011-2012. Following the filing of a class action lawsuit in *Darling v. Douglas* (C-09-3798-SBA) U.S. District Court, Northern District of California, to enjoin the elimination of ADHC, a settlement was reached to replace AHDC with CBAS, effective April 1, 2012.

Community-Based Adult Services (CBAS):

The following pertinent parts are taken from the CENTERS FOR MEDICARE & MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, Amended Effective April 1, 2012, NUMBER: 11-W-00193/9 (State Plan), relating to the CBAS program:

Community-Based Adult Services (CBAS) and Enhanced Case Management (ECM) for Medi-Cal State Plan Populations

91. Community-Based Adult Services (CBAS) Eligibility and Enrollment. —Community Based Adult Services is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to certain State Plan beneficiaries.

a. CBAS Program – must be operational for the period from April 1, 2012, through August 31, 2014, for CBAS Beneficiaries who:

i. Are those persons who are age 18 years and older;

ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.

b. CBAS Program Enrollment Criteria - The CBAS benefit will be available to all CBAS beneficiaries who qualify based on the medical criteria in (i) through (vi) and comply with the requirement in (vii) to enroll in managed care for CBAS services:

- i. Meet medical necessity criteria as established by the State;
 - ii. Meet —Nursing Facility Level of Care A (NF-A) criteria as set forth in the California Code of Regulations, or above NF-A Level of Care; or
 - iii. Have a moderate to severe cognitive disorder such as Dementia, including Dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 of the Alzheimer's Type; or
 - iv. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, AND needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;
 - v. Have a developmental disability. —Developmental disability means a disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations, or;
 - vi. Have a chronic mental disorder or acquired, organic, or traumatic brain injury. —Chronic mental disorder means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:
 - a) Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
 - b) One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation.
 - vii. Enrollment for Non-CBAS services – No sooner than July 1, 2012, if the CBAS beneficiary is eligible to enroll in a managed health care plan in the counties specified in Attachment O, the CBAS beneficiary must be enrolled in the managed care plan to receive the CBAS benefit. This requirement does not apply to otherwise eligible CBAS beneficiaries residing in a county that is not listed in Attachment O or who are exempted from or ineligible for enrollment in a managed care plan.
- c. CBAS Patient Protections –
- i. No Disruptions in Care –State Plan Beneficiaries who previously received Adult Day Health Care Services between July 1, 2011, and February 29, 2012, must have a face to

face assessment to determine CBAS enrollment qualification, but there will be no disruption in care until the face to face assessment has been conducted.

ii. Second Level Review – State Plan Beneficiaries who previously received Adult Day Care Services between July 1, 2011, and February 29, 2012, and have been determined not to meet the level of care for CBAS by the Department or a managed health care organization may request a second level review. The second level review may be requested by the beneficiary, their family, or guardian. An individual must continue to receive CBAS services if the individual was receiving CBAS prior to being determined ineligible for CBAS until the second level review has been completed by an entity/agency independent of the initial assessment reviewer. Individuals determined not eligible must have a Discharge Plan of Care completed and provided in writing to the individual, family member, or guardian.

iii. Continuity of Care - In referring a beneficiary for CBAS services under paragraph 91(d)(iii) to a CBAS Center, consideration will be given to the CBAS beneficiary's relationship with previous providers of similar services

iv. Discharge Plan of Care – State Plan and CBAS beneficiaries determined not in need of CBAS services will be provided a written Discharge Plan of care to be completed by a CBAS center. The Discharge Plan of care must contain:

- a) The name(s) of the patient's physician(s) and the patient's ID number.
- b) The date the Notice was issued.
- c) The date the CBAS services are to end.
- d) Specific information about the patient's current medical condition, treatments and medication regime.
- e) A statement about Enhanced Case Management Services and how they will be provided to those eligible State plan beneficiaries
- f) A statement of the right to file a Grievance or Appeal, or to request a second level review.
- g) A space for the beneficiary or representative to sign and date the document.

v. Grievances and Appeals – Individuals who receive a notice of adverse action are entitled to file a Grievance or Appeal as they are entitled under State and Federal law.

vi. The State must submit to CMS for review the notices of adverse action that will be sent to CBAS beneficiaries outlining their new services and due process rights, before they are sent to the beneficiaries.

d. CBAS Assessment. Assessment for the CBAS benefit will be performed as follows:

i. The initial assessment for the CBAS benefit will be performed through a face-to face review by a registered nurse with level of care experience, using a standardized tool and protocol approved by the State Medicaid Agency. The assessment may be conducted by the State Medicaid Agency or its contractor(s), including a CBAS beneficiaries' Managed Care Plan.

- ii. CBAS beneficiaries' eligibility must be re-determined at least every six months, or whenever a change in circumstances occurs that may require a change in the individual's CBAS benefit.
- iii. CBAS will be provided:
 - a. To CBAS beneficiaries who have been referred for an assessment, are assessed, and are determined to meet the eligibility criteria in 91(a);
 - b. State Plan Beneficiaries who previously received Adult Day Health Care (ADHC) services between July 1, 2011, and February 29, 2012, and are assessed and determined to meet the eligibility criteria in 91(a);
 - c. State Plan Beneficiaries who previously received ADHC services between July 1, 2011, and February 29, 2012, and who have not yet been assessed by the State Medicaid Agency for eligibility for CBAS; or
 - d. State Plan Beneficiaries who previously received ADHC services between July 1, 2011, and February 29, 2012, and who have been determined to be ineligible for CBAS, but for whom a care plan has not been developed and/or acted upon.

([http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/forms/2012/1115 Bridge to Reform Waiver.pdf](http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/forms/2012/1115_Bridge_to_Reform_Waiver.pdf), pp. 1 and 44-46)

Settlement Agreement:

The DHCS amended the State Plan to include the CBAS program, as a Medi-Cal waiver service, pursuant to the Settlement Agreement in *Darling v. Douglas*. The Settlement Agreement, at Section X, contains the provisions for determining eligibility for CBAS services.

Initial assessments for CBAS eligibility are made after the DHCS identifies those ADHC recipients who are determined, by the DHCS, to be categorically eligible for CBAS or presumptively eligible for CBAS. (Settlement Agreement, Section X.A.1.)

"Categorically eligible" ADHC recipients are persons who were: Regional Center clients; Multi-Purpose Senior Services Program (MSSP) clients; eligible for Specialty Mental Health Services; and/or eligible to receive 195 or more hours of In-Home Supportive Services (IHSS) per month. Settlement Agreement, Section VI.4. Categorically eligible class members will transition from ADHC to CBAS as a fee-for-service program without interruption and at their current level of ADHC service. (Settlement Agreement, Section XI.B.1.)

"Presumptively eligible" ADHC recipients were persons who are: likely to meet NF-B level of care (as set forth in 22 Cal. Code Regs §§ 51334(j) and §51124), as determined by DHCS, and whose ADHC IPCs indicate a need for supervision with three (3) of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene, and one nursing intervention at ADHC. Settlement Agreement, Section VI.19. Presumptively eligible class members will transition from ADHC to CBAS as a fee-for-service program without interruption, and at their current level of service, and will continue to be eligible for CBAS at their current level of service at least until a face-to-face assessment by DHCS as set forth in Section XI.A.3. (Settlement Agreement, Section XI.B.2.a.)

For purposes of the Settlement Agreement, a "class member" is a Medi-Cal beneficiary in the State of California for whom ADHC benefits was eliminated under the provisions of AB 97. (Settlement Agreement, Section VII.)

Face-to-face initial assessments for eligibility for CBAS benefits shall be conducted, prior to the termination of any class member's ADHC services, by teams of DHCS nurses with experience in level of care assessments. (Settlement Agreement, Section XI.A.3.a.)

A tool and protocol used by the DHCS for conducting face-to-face assessments for CBAS eligibility is to be created by the parties to the Settlement Agreement. Settlement Agreement, Section XI.A.3.c. Prior to conducting face-to-face assessments, DHCS shall conduct training for its assessment team staff. (Settlement Agreement, Section XI.A.3.e.)

"Second level" reviews must be conducted by a DHCS nurse supervisor in all cases in which the outcome of a face-to-face assessment is that a class member is not eligible for CBAS, except when the class member previously was identified by the ADHC center as not meeting CBAS eligibility criteria. Then a second level review will be conducted only upon the request of the class member or the class member's family. (Settlement Agreement, Section XI.A.4.a. and c.)

Class Members whose ADHC centers determine that they do not meet CBAS eligibility criteria shall be immediately given information about their option to request a face-to-face assessment, as set forth in Section XI.A.3, and ADHC services shall be available until the outcome of any requested face-to-face assessment and any requested second level review. (Settlement Agreement, Section XI.B.4.a. and c.)

No sooner than six (6) months after being determined eligible for CBAS or transitioning to CBAS through managed care, whichever is later, or upon a change in circumstances requiring an increase in the level of CBAS services, or transitioning to CBAS through managed care, whichever is later, or upon a change in circumstances requiring an increase in the level of CBAS services, class members may be reassessed for CBAS eligibility. (Settlement Agreement, Section XI.C.1.)

It is the responsibility of the DHCS to provide quality assurance monitoring and oversight to all class members. Quality assurance activities performed by the DHCS shall include monitoring the quality and accuracy of the screening and assessment of class members for CBAS services and the actual provision of services to class members by providers, managed care plans and APS, and shall include reviews of data, random sampling of files and in person reviews with individuals whose files are examined. Quality assurance activities shall be focused on measuring whether services are provided to class members in accordance with the Settlement Agreement. (Settlement Agreement, Section XVI.B.)

One of the ways that a claimant may be eligible for CBAS is if he or she is categorically eligible. If categorically eligible, the claimant receives CBAS benefits at their current level of service until at least a regularly scheduled reassessment is conducted. (Settlement Agreement § XI.B.1.)

A claimant who was receiving ADHC services may be categorically eligible for CBAS if DHCS determines that he or she was: a Regional Center client; a Multi-Purpose Senior Service Program (MSSP) client; eligible for Specialty Mental Health services; or eligible to receive 195 or more hours of In-Home Supportive Services (IHSS) per month. (Settlement Agreement § VI.4.)

However, the denial of categorical eligibility is not subject to appeal at a state fair hearing as it is not a "final determination of ineligibility" as defined by the settlement agreement. (Settlement Agreement § XIV.B.)

An additional way a claimant may be eligible for CBAS is if DHCS determined that he or she was presumptively eligible. (Settlement Agreement § XI.A.1.b.)

The NF-B level of care is set forth in Title 22 California Code of Regulations sections 51334(j) and 51124.

A presumptively eligible claimant is one who was receiving ADHC and who is likely to meet NF-B level of care as determined by DHCS or whose ADHC Individual Plan of Care indicates a need to assistance or supervision with three of the following ADLs/IADLs: bathing dressing, self-feeding, toileting, ambulation, medication management and hygiene, and one nursing intervention at ADHC. (Settlement Agreement § VI.19.)

The denial of presumptive eligibility is not subject to appeal at a state fair hearing. (Settlement Agreement Addendum § 2.b.)

An additional way for a claimant to be eligible for CBAS is if he or she is determined to be diagnostically eligible. (Settlement Agreement § X.) Although this method of eligibility includes several specific categories, it is distinct from "categorically eligible" as described above. To be eligible the claimant must meet the criteria of one of five categories of CBAS eligibility. The categories are generally referenced by number: Category 1, nursing facility A (NF-A) or above; Category 2, brain injury or chronic mental health; Category 3, Alzheimer disease or other dementia (severe); Category 4, Alzheimer disease or other dementia (moderate); and Category 5, developmental disability. (Although generally referenced by number in the parties' documents, the Settlement Agreement lists the categories by the letters A – E.)

With regard to diagnostic eligibility, the Settlement Agreement states, in pertinent part:

X. ELIGIBILITY FOR CBAS SERVICES

The following individuals shall meet the criteria for eligibility for CBAS if they meet the criteria of any one or more in the following categories:

A. (Category I): Individuals who meet NF-A Level of Care or Above

1. Meet NF-A level of care as defined in Section VI of this Agreement or above;

AND

2. Meet ADHC eligibility and medical necessity criteria contained in sections 14525(a),(c),(d),(e), 14526.1(d)(1),(3),(4),(5), and 14526.1(e) of the California Welfare and Institutions Code.

B. (Category II) Individuals who have an Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness

1. Have been diagnosed by a physician as having an Organic, Acquired or Traumatic Brain Injury, and/or have a Chronic Mental Illness, as defined in

Section VI of this Agreement;

AND

2. Meet ADHC eligibility and medical necessity criteria contained in sections 14525 and 14526.1(d) and (e) of the California Welfare and Institutions Code.
3. Notwithstanding sections 14525(b) and 14526.1(d)(2)(A) of the California Welfare and institutions Code, the individual must demonstrate a need for assistance or supervision with at least:
 - a. Two (2) of the following ADL,s/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; OR
 - b. One (1) ADL/IADL listed in (a) above, and money management, accessing resources, meal preparation, or transportation.
4. For eligibility purposes, applicants/recipients do not need to show a need for a service at the center providing CBAS services to be included in the qualifying ADL/IADLs (including money management, accessing resources, meal preparation, and transportation).

C. (Category III): Individuals with Alzheimer's Disease or other Dementia

1. Individuals have moderate to severe Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5 6, or 7 Alzheimer's Disease;

AND

2. Meet ADHC eligibility and medical necessity criteria contained in Welfare and institutions Code sections 14525(a),(c),(d),(e), 14526.1(d)(1),(3),(4),(5), and 14526.1(e).

D. (Category IV): Individuals with Mild Cognitive Impairment including Moderate Alzheimer's Disease or other Dementia

1. Individuals have mild cognitive impairment or moderate Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's Disease;

AND

2. Meet ADHC eligibility and medical necessity criteria contained in sections 14525 and 14526.1(d) and (e) of the California Welfare and Institutions Code.
3. Notwithstanding sections 14525(1) and 14526.1(d)(2)(A) of the California Welfare and Institutions Code, the individual must demonstrate a need for assistance or supervision with two of the following ADLS/IADLS: bathing, dressing, self-

feeding, toileting, ambulation, transferring, medication management, and hygiene.

4. For eligibility purposes, applicants/recipients do not need to show a need for a service at the center providing CBAS services to be included in the qualifying ADLS/IADLs.

E.(Category V) :Individuals who have Developmental Disabilities

1. Meet the criteria for regional center eligibility as defined in Section VI of this Agreement;

AND

2. Meet ADHC eligibility and medical necessity criteria contained in sections 14525(a),(c),(d),(e), 14526.1(d)(1),(3),(4),(5), and 14526.1(e) of the California Welfare and Institutions Code.

(Settlement Agreement §X)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

- (a) The person is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.
- (b) The person has functional impairments in two or more activities of daily living, instrumental activities of daily living, or one or more of each, and requires assistance or supervision in performing these activities.
- (c) The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.
- (d) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
- (e) Notwithstanding the criteria established in subdivisions (a) to (d), inclusive, of this section, any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(W&IC§14525)

- (d) Except for participants residing in an intermediate care facility/ developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:
- (1) The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:
 - (A) Monitoring.
 - (B) Treatment.
 - (C) Intervention.
 - (2) The participant has a condition or conditions resulting in both of the following:
 - (A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.
 - (B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). That assistance or supervision shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.
 - (3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
 - (A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
 - (B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.
 - (C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
 - (4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to

result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

- (5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5, on each day of attendance that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.
- (e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

(W&IC§14526.1)

ADHC centers shall offer and provide on premises in accordance with an individual's plan of care one or more of the following professional nursing services to each participant during each day of the participant's attendance at the center:

- 1) Observation, assessment, and monitoring of the individual's general health status and changes in his or her condition, risk factors and the participant's specific medical, cognitive or mental health conditions upon which admission to the center was based;
- 2) Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications, and intervention, as needed, based upon the assessment and the participant' reactions to the medications;
- 3) Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms;
- 4) Supervision of the provision of personal care services for the participant and assistance as needed;
- 5) Provision of skilled nursing care and intervention, within the scope of practice, to participants, as needed, based upon an assessment of the participant, his or her ability to provide self-care while at the adult day health care center, and any health care provider orders.

(W&IC §14550.5(a))

Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:

- (1) Require protective and supportive care because of mental or physical conditions above the level of board and care.
- (2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief respite spells of illness.

- (3) Do not have an illness, injury or disability for which hospital or skilled nursing facility services are required.

(§51120(a))

In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. As a guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement:

- (1) The complexity of the patient's medical problems is such that he or she requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.
- (2) Medications require professional nurse observation for response and effect on an intermittent basis.
- (3) Diet of a special type but the patient needs little or no assistance in feeding.
- (4) Minor assistance or supervision may be required in personal care such as bathing or dressing.
- (5) A need for encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence.
- (6) Some degree of vision, hearing or sensory loss.
- (7) Some limitation in movement, but the patient is ambulatory with or without an assistance device.
- (8) Some supervision or assistance needed in transferring to a wheelchair.
- (9) Occasional incontinence of urine; a patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care when he or she has been taught and can care for him- or herself.
- (10) Mild confusion or depression, but the behavior must be stabilized to such an extent that it poses no threat to him- or herself or others.

(§51134(l))

- (e) Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi-Cal Authorization," published by the Department in January 1982, last revised January 1, 2006, and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi-Cal consultants or PCCM plans in their decisions on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified

by the Medi-Cal consultant or PCCM plan up to a maximum of 180 days, unless otherwise specified in this chapter. The Medi-Cal consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years.

- (f) Authorization may be granted only for the lowest cost item or service covered by the Medi-Cal program that meets the beneficiary's medical needs.

(22 CCR §51003)

A claimant who was determined to be ineligible for CBAS prior to April 1, 2012, but who is determined to be eligible for CBAS by state fair hearing decision, will be eligible for CBAS retroactive to April 1, 2012. (Settlement Agreement Addendum § 2.b.)

CONCLUSION

The issue presented in claimant's appeal is whether she qualifies for CBAS services under the terms of the settlement agreement adopted by the court in *Darling v. Douglas* and an amendment to the State's Medicaid plan approved by the U.S. Department of Health and Human Services.

The basis of the DHCS denial is its determination that claimant does not meet the ADHC medical necessity criteria set forth in W&IC §14525(c) and 14526.1(d)(4).

The claimant has disputed the February 7, 2012 CA Department of Health Care Services action denying her CBAS benefits on two grounds. First, she alleges pursuant to *Darling v. Douglas*, the Department does not have the authority to overturn the face-to-face RN assessor's finding the claimant was eligible for CBAS. Second, the claimant disputes the Department's determination she did not meet the CBAS eligibility requirements under Category II. Because the CA Department of Health Care Services alleged the only reason the claimant did not meet the CBAS eligibility requirements for Category II was that she did not meet the medical necessity criteria contained in W&I Code sections 14525 and 14526.1(d) and (e), these will be the only Category II requirement that are addressed in this decision.

Review of Assessor's Determination

The Director concludes that the Department does have the authority to (1) review a nurse reviewer's initial assessment of CBAS eligibility and (2) disagree with that assessment in making the final decision about a person's eligibility for CBAS services.

- The language of the Settlement Agreement (SA) makes a clear distinction between "eligibility determinations" and "face-to-face assessments." If the "face-to-face assessment" were the sole determining factor for CBAS eligibility, the SA would have unambiguously read "if the face-to-face assessment determines a [non-presumptively eligible] class member to be eligible for CBAS, the class member will transition from ADHC to CBAS..." Such prescriptive language does not appear in the SA nor would the Department have agreed to this language in negotiating the SA.

- Nowhere does the SA define “face-to-face assessments” as “the final determination of CBAS eligibility,” nor does it explicitly limit quality assurance and second-level reviews **only** in cases where the initial face-to-face assessment indicates that the person is ineligible for CBAS. The Department would not have agreed to such language in the SA negotiations.
- Quality assurance is part of the CBAS eligibility determination process. The SA makes it clear that “quality assurance activities performed by the DHCS shall include monitoring the quality and accuracy of the screening and assessment of class members for CBAS services...” Additionally, the CEDT, developed in consultation with Plaintiff’s representatives, provides for a quality assurance review for every initial face-to-face determination. This clearly makes quality assurance an important part of the CBAS eligibility determination process.
- The SA language contains no restrictions on second level reviews. The word **only** appears solely in relationship to the exception of a second-level review not being automatic when the center has determined that the person does not meet CBAS eligibility criteria; in these cases the second-level review is done “only upon the request of the Class Member and/or Class Member’s family.”
- The State Plan does not prohibit or limit the Department from exercising its administrative authority to operate the CBAS portion of the Medi-Cal program in an effective and efficient manner, in accordance with waiver requirements as required by Centers for Medicare and Medicaid Services (CMS).
- The Department’s procedure for not providing findings of the face-to-face assessment to the participants and the CBAS centers on-site indicates that the final determination of eligibility is made after the quality assurance and second-level reviews take place.

Medical Necessity standard set forth in CA Welfare and Institutions Code, section 14525 and 14526.1(d) and (e):

Because the Director of the Department of Health Care Services has alternated the part of this decision in which it was asserted that the Department cannot overturn the face-to-face RN assessor’s finding the claimant was eligible for CBAS, then it must be decided whether the claimant meets the CBAS eligibility criteria requiring the medical necessity requirements set forth in W&IC sections 14525 and 14526.1(d).

The ADHC program ended on March 31, 2012. The CBAS program is a new program and the claimant must establish she meets the criteria for eligibility. It is therefore determined the claimant carries the burden of proof of establishing by a preponderance of the evidence whether the medical necessity requirements set forth in W&IC sections 14525 and 14526.1 are met. Based on the testimony and the documents admitted into evidence and law, it is determined the claimant did not establish by a preponderance of the evidence that the medical necessity requirements set forth in W&IC sections 14525 and 14526.1 were met.

During the testimony, the Department’s representative testified credibly that each of the monitoring, observing and interventions being performed by skilled medical personnel at the

ADHC center could easily be performed by the claimant's primary physician, her pharmacist or by non-medical personnel such as the claimant's IHSS provider or other family members without causing the claimant's medical condition to deteriorate or increasing her risk of requiring emergency department visits, hospitalization, or other institutionalization.

While the claimant's Authorized Representative testified the claimant trusted the medical staff at the ADHC and used them to mediate the disagreements she had with her daughter-in-law, this provided an insufficient basis for granting CBAS benefits. Further, the claimant's Authorized Representative failed to establish the claimant's social service needs could not be met by being assigned an Enhanced Case Manager, who could refer her other less costly adult social programs, where she could socialize with other seniors to decrease her loneliness and depression. Although the Authorized Representative testified the claimant's inability to speak any language other than Cantonese was a deterrent to being able to communicate with other attendees at the social programs, the Authorized Representative failed to establish the claimant would not meet other Cantonese-speaking attendees at these programs.

Accordingly, it is determined the claimant was not eligible for CBAS services, because the claimant failed to establish she met the medical necessity criteria set forth in the CA W&IC sections 14525 and 14526.1(d).

ORDER

The claim is denied.

Department of Health Care Services
Index of Precedential Decisions
Government Code Section 11425.60(b)

Decision #	Subject	Effective Date
12-001	Eligibility for Community-Based Adult Services	Sept. 17, 2012