



Community Based Adult Services (CBAS)
New Fee-For-Service Eligibility Determination
Process Training – For CBAS Providers
with
California Dept. of Health Care Services
California Dept. of Aging

March 6, 2013

1. Introductions
2. Overview - CBAS Eligibility Determination Tool (CEDT v2.0) (10 min)
3. New FFS Eligibility/Adjudication Process Requirements (40 min)
4. CBAS Center Operations and the New FFS Process (15 min)
5. Review - Eligibility Categories & Medical Necessity Criteria (10 min)
6. LOS Recommendation Considerations (20 min)
7. Summary and Questions (25 min)

Overview – CEDT v2.0

- Convened: October 2012
- Purpose: To establish an updated version of the CEDT by:
 - Identifying and prioritizing issues w/existing CEDT and related business/completion processes
 - Defining next operational version of the CEDT and associated business/completion processes
- Participants: Key Stakeholders - DHCS, CDA, Managed Care Plans, CBAS Providers, CBAS Participant Community

- Initial Planning Session – October 10, 2012
- Six Working Sessions – October and November 2012
- Revised CEDT Prototype Development
- Development of Instructions for Completion
- Beta Testing
- Implementation – April 1, 2013

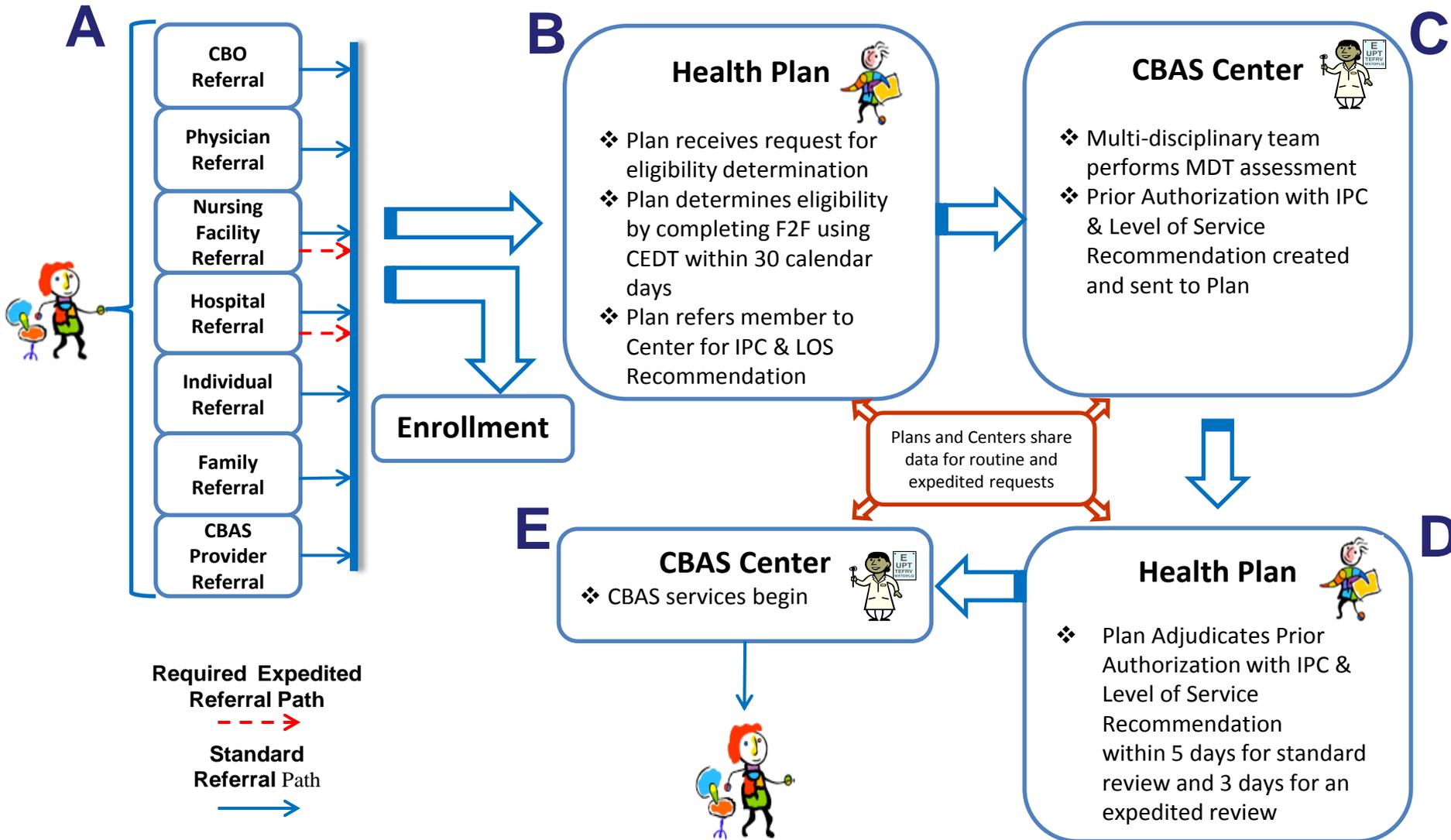
- Concurrent with CEDT Version 2.0 implementation on April 1st, new eligibility/adjudication process for fee-for-service CBAS participants
- Medi-Cal Provider Bulletin will be issued March 15, 2013

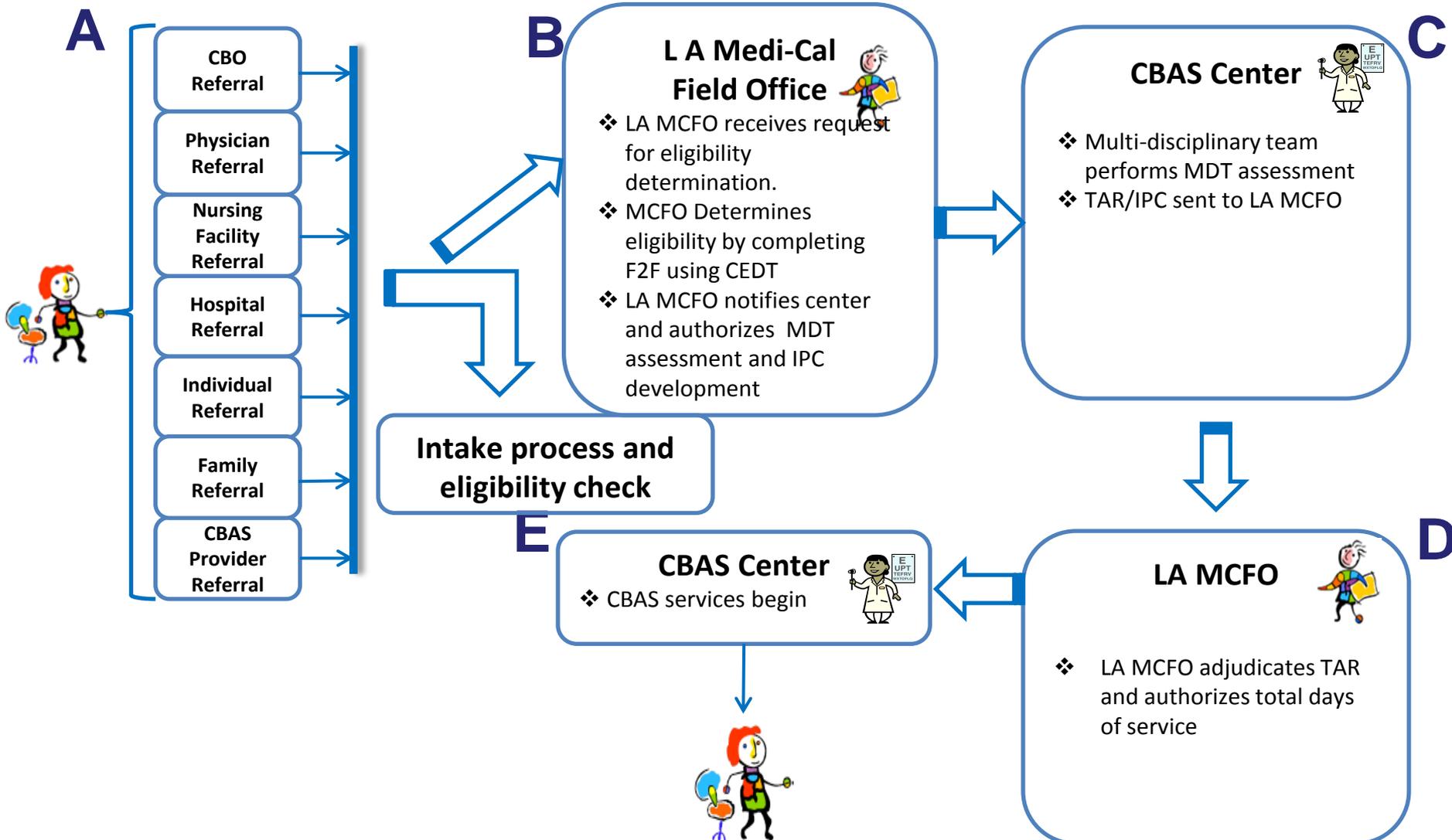
CBAS Eligibility Determination Tool (CEDT) – Version 2.0

- Elimination of fields no longer relevant
- Three main sections:
 - ❖ I – Assessment/Evaluation
 - ❖ II – AE & MN Criteria
 - ❖ III – Eligibility Outcome
- Signature Page
- Comments Page
- Instructions

CEDT v2.0 Walk Through

New FFS Eligibility/Adjudication Process Requirements





- CDA sent All Center Letter (#13-05) March 6th detailing new process
- Effective April 1, 2013, all new Medi-Cal fee-for-service beneficiaries wanting to participate in CBAS, are subject to the following process:
 - Steps 1-3: CBAS Provider Responsibilities
 - Steps 4-7: DHCS UMD Responsibilities
 - Step 8: CBAS Provider Responsibilities
 - Step 9: DHCS UMD Responsibilities
 - Step 10: CBAS Provider Responsibilities

CBAS Provider Responsibilities:

- Identifies prospective participant.

CBAS Provider Responsibilities:

- Checks Medi-Cal eligibility system for current Medi-Cal status:
 - Beneficiary eligible for Medi-Cal and NOT eligible for Medi-Cal Managed Care enrollment (e.g., beneficiary resides in a non-managed care county, is enrolled in a non-matching Medicare plan, resides in a long-term care facility).
- **GO TO STEP 3**

CBAS Provider Responsibilities:

- Submits CBAS eligibility inquiry request to Los Angeles Medi-Cal Field Office (LAMFO) via fax: (213) 897-1740

- There is no specific form required, but each request must include the following information:
 - Center Name
 - Center NPI
 - Center Contact Name
 - Contact Telephone Number
 - Center Fax Number
 - Beneficiary Name
 - Beneficiary Medi-Cal ID Number (CIN)
 - Beneficiary Birthdate

CBAS Eligibility Inquiry

Center Name: _____

NPI: _____

Center Contact: _____

Contact Number: _____

Center Fax: _____

Beneficiary Name: _____

Beneficiary CIN: _____

Beneficiary DOB: _____

DHCS UMD Responsibilities:

- Verifies beneficiary eligibility status.
- If beneficiary is required to enroll in Medi-Cal managed care to obtain CBAS:
 - Immediately notifies CBAS center by fax that beneficiary is required to enroll in Medi-Cal managed care.
- If beneficiary is NOT required to enroll in Medi-Cal managed care to obtain CBAS because they are exempt:
- **GO TO STEP 5**

DHCS UMD Responsibilities:

- LAMFO will either:
 - Contacts the CBAS center to schedule the face-to-face (F2F) eligibility determination visit; **OR**
 - Forwards the request for a F2F eligibility determination to the appropriate field office.
- The field office will make two attempts to schedule the F2F with the CBAS center within 14 calendar days of receipt of the initial inquiry at the LAMFO. If the second attempt is unsuccessful, the field office will fax the CBAS center notice that the center must submit a new eligibility inquiry request.

DHCS UMD Responsibilities:

- The state nurse assessor completes the CBAS Eligibility Determination Tool (CEDT) during the F2F visit at the center. No information regarding results will be shared with the CBAS center or the beneficiary or caregiver at that time.
- NOTE: For the purpose of an independent determination of CBAS eligibility, assessors are instructed to accept only documentation for review that has been developed by staff **NOT** affiliated with the center (e.g., history and physical from an external primary care provider).

DHCS UMD Responsibilities:

- After returning to the field office, the nurse assessor confers with her/his supervisor to finalize determination. Within one business day of the final decision and within 30 days after LAMFO receives the initial CBAS eligibility inquiry request, the field office faxes the eligibility decision to the CBAS center.
- NOTE: If F2F conducted by a field office other than LAMFO, that field office will then send the CEDT and any other eligibility determination documents to LAMFO for retention.

Ineligible Determination

- Field office faxes determination to center and generates a Notice of Action (NOA) to inform beneficiary of ineligible determination and his/her state hearing rights.

Eligible Determination

- Field office faxes determination results to center authorizing the center's multidisciplinary team (MDT) to conduct assessments and develop the Individual Plan of Care (IPC). Up to three assessment days are allowed. No TAR is required for assessment days, and the provider may bill for these days directly to the fiscal intermediary.

CBAS Provider Responsibilities:

- Submits completed IPC and treatment authorization request (TAR) to LAMFO for adjudication.
- NOTE: The center must complete the MDT assessments, develop the IPC, and submit the TAR within 30-days of the date of the fax notifying the CBAS center of the eligible determination.

DHCS UMD Responsibilities:

- LAMFO adjudicates all TARs for beneficiaries determined eligible regardless of which field office conducted the F2F. When the TAR is approved, LAMFO calculates days authorized for the approved time period and includes in an adjudication response.

CBAS Provider Responsibilities:

- Begins providing CBAS.
- NOTE: If CBAS provider starts providing services prior to notification of the approved TAR through the usual TAR adjudication process from the LAMFO, they do so at risk of no reimbursement if the field office does not authorize the recommended number of days the provider has requested.

CBAS Center Operations and the New FFS Process

First meeting/contact with prospective participant:

- Center initiates usual practices of gathering and giving information begins:
 - Gathering background information on prospective participant
 - Name, address, phone, . . .
 - General health information
 - Daily needs, home supports, caregiver information
 - Medi-Cal/Managed Care eligibility status
 - ...

- Providing prospective participant information:
 - Medi-Cal Managed Care enrollment requirements (as appropriate), including phone number for HCO (1-800-430-4263)
 - Need for History and Physical from Personal Care Provider to start program
 - Expectations for F2F, including bringing any health record documentation they have
 - Timeframes for enrollment/CBAS start

- Data Tracking/Reporting

- Dates:

- Initial inquiry
- Eligibility determination
- Start of service



Monthly Statistical Summary Report (MSSR)

Review Eligibility Categories & Medical Necessity Criteria References

- Welfare and Institutions Code, 14525 and 14526.1, and 14550 and 14550.5
- Darling v. Douglas Settlement Agreement
- California Bridge to Reform Demonstration Waiver, Special Terms and Conditions, Page 44 – 56
- Detailed Criteria Matrix:
 - www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/forms/2012/CBAS_Eligibility_Criteria-Table_05232012.pdf
- CEDT v2.0 includes Eligibility and MN Criteria

Review - 5 Categories of CBAS Eligibility References

Meet the criteria of any one or more in the following 5 categories:

Category 1: Individuals who meet NF-A Level of Care or Above

Meet NF-A level of care as defined in Section VI of the *Darling v Douglas* Settlement Agreement or above;

AND

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.

Category 2: Individuals who have an Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness

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 the *Darling v Douglas* Settlement Agreement;

AND

Meet ADHC eligibility and medical necessity criteria contained in sections 14525 and 14526.1(d) and (e) of the California Welfare and Institutions Code.

AND

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:

Two (2) of the following ADL,s/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene;

OR

One (1) ADL/IADL listed in (a) above, and money management, accessing resources, meal preparation, or transportation.

Category 3: Individuals with Alzheimer's Disease or other Dementia

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

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).

Category 4: Individuals with Mild Cognitive Impairment including Moderate Alzheimer's Disease or other Dementia

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

Meet ADHC eligibility and medical necessity criteria contained in Sections 14525 and 14526.1(d) and (e) of the California Welfare and Institutions Code.

AND

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 at least:

Two of the following ADLS/IADLS: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

Category 5: Individuals who have Developmental Disabilities

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

AND

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.

Review - Required ADHC Core Services Review

ADHC shall offer, and provide directly on the premises, in accordance with the Participant's plan of care: the following core services to each Participant during each day of the Participant's attendance at the center:

- Professional nursing
- Social services and/or personal care services
- Therapeutic activities
- One meal offered per day

One or more of the following (5) professional nursing services:

1. Observation, assessment, and monitoring of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions **upon which admission to the ADHC 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's reactions to his/her medications.
3. Oral or written communication with the participant's personal health care provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs, or symptoms.
4. Supervision of the provision of personal care services for the participant, and assistance, as needed.
5. Provision of skilled nursing care and intervention, within scope of practice, to participant, as needed, based upon an assessment of the participant, his or her ability to provide self-care while at the ADHC, and any other health care provider orders.

One or both of the following core personal care services or social services:

1. One of both of the following personal care services:
 - (A) Supervision of, or assistance with, activities of daily living or instrumental activities of daily living.
 - (B) Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.
2. One or more of the following social services provided by the ADHC social worker or social worker assistant:
 - (A) Observation, assessment , and monitoring of the participant's psychosocial status
 - (B) Group work to address psychosocial issues
 - (C) Care coordination

At least one of the following therapeutic activities provided by the ADHC center activity coordinator or other trained ADHC center personnel:

- 1. Group or individual activities to enhance the social, physical, or cognitive functioning of the participant.**
- 2. Facilitated participation in group or individual activities for those participant's whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.**

Required ADHC Core Services

Welfare and Institutions Code, Section 14550.5(d)

One meal per day of attendance, unless the participant declines the meal or medical contraindications exist, as documented in the participant's health record, that prohibit the ingestion of the meal.

Level of Service (LOS) Criteria and Considerations

- Multidisciplinary Team:
 - When considering the appropriate number of days per week to recommend:
 - Medi-Cal Provider Manual – Community IPC Section
 - Title 22, CCR, Section 54209
 - Title 22, CCR, Section 54223

1. Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days
2. Frequency of services needed
3. The extent to which other services currently being received by the recipient meet the recipient's needs
4. If the personal health care provider or CBAS center physician has requested a specific number of days
5. When requesting the number of days per calendar month, the provider must ensure that the request is related to the participant's problem(s) and the number of days needed to carry out the IPC.

- Medical Factors – Necessity For:
 - Intermittent nursing care to abate health deterioration
 - Intermittent monitoring of medications for response and effect
 - Medications that cannot safely be self-administered due to physical or mental disabilities
 - Individualized therapeutic treatment designed to restore optimal functional potential or prevent deterioration

- Functional Status, including:
 - Limitation in movement, with or without an assistive device such as cane, walker, crutches, prosthesis or wheelchair or need for training in use of these devices
 - Inability to perform toileting, bathing, eating, dressing, grooming, transferring and self-medication or need for training and assistance in ADLs
 - Incontinency and probable benefit from continence retraining
 - Vision, hearing or sensory loss to some degree
 - Dependency and the need for part-time or full-time basic supervision

- Psychosocial Limitations, including:
 - Inability of person or family to cope adequately with problems associated with person's disability
 - Need for psychosocial environment involving peer group membership and social rehabilitation
 - Mild or moderate confusion or depression
 - Tendency to wander
 - Inappropriate affect, appearance, or behavior

- Treatment needs of participant shall determine frequency and duration of attendance
- Number of days shall be governed by least time needed to carry out IPC
- Participants shall not be encouraged to attend more frequently than necessary for achievement of individual goals and objectives

- MDT's - The IPC should support the days you recommend.
- What's in your IPC?
 - Does the care plan address participant medical, functional, psychosocial problems?
 - Do treatments and interventions scheduled address identified problems?
 - Is the need for the frequency of scheduled services and/or supervision clear?
 - Are the stated goals and objectives related to the problems and achievable with the treatments/interventions?
 - Is the care plan individualized to restore optimal function or abate deterioration?

- Does the IPC address:
 - Issues related to the participant's CBAS Category (1-5)
 - Conditions that require treatment?
 - ADL/IADL limitations?
 - Necessary care or supervision that's lacking at home?
 - Risks the beneficiary has for institutional services?
 - Need for each CBAS core daily services?
- IPC Box 23 includes additional information/ explanations not included elsewhere?

Summary and Closing Questions

Thank You!