



Community Based Adult Services (CBAS) Frequently Asked Questions February 2012

Billing Questions

1. Q: Will we receive training on new billing processes?

A: Billing for CBAS services between March 1, 2012, and June 30, 2012, will remain the same as under the current ADHC program. For billing processes under managed care which will begin July 1, 2012, information will be provided by the managed care plans with which your center contracts for the provision of CBAS services.

2. Q: Is there a mechanism in place to avoid delay of benefit payment when ADHC benefits stop and CBAS benefits begin?

A: Yes.

CBAS Provider/Program Requirement Questions

3. Q: Where can I find the CBAS Participation Agreement (IMS 36 Rev 12/11)?

A: Go to the CDA webpage, click on the ADHC tab. The third arrow under the CBAS Implementation "Provider Application Package," you will find the CBAS Participation Agreement form. www.aging.ca.gov/programs/ADHC

4. Q: Can a center reapply for CBAS status?

A: Applications to become a CBAS provider are due by January 27, 2012. No initial applications for CBAS will be accepted beyond that date. Approved CBAS providers will maintain their current ADHC certification period, modified to begin March 1, 2012, and end as scheduled on their previously approved ADHC Participation Agreement. CDA will mail you a renewal application package prior to expiration, as is currently the renewal process.

5. Q: Our license will expire in April. Should we pay for CBAS licensing/certification?

A: Yes. CBAS providers are required to have an active unencumbered license. If your license expires due to non-payment of fees, you will not be eligible for continuing participation as a CBAS provider.



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6. Q: Upon certification or approval as a CBAS center, will a list of managed care entities be provided such that the CBAS center may apply as a member?

A: A list of Medi-Cal managed care organizations by county is available now at the following link: www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

Additionally, Medi-Cal managed care plans whose beneficiaries are determined to be eligible for CBAS will begin reaching out to approved CBAS providers after March 1st.

7. Q: Do we need to create a new policy manual for CBAS?

A: Yes, in some instances. CBAS requirements are very similar to ADHC, so most of your current policies and procedures (P&Ps) will apply. New eligibility and medical necessity requirements should be reflected in your intake and assessment P&Ps. New quality assurance requirements under the 1115 will also need to be incorporated into your CBAS P&Ps in the future, as well as any new requirements for contracting with managed care organizations.

8. Q: Do we still need to have flow sheets for activities, OT/PT maintenance, and social services?

A: Requirements for documentation of services in the current ADHC program will continue to apply to the new CBAS program, including documentation of the provision of all required services.

9. Q: Do the OT and PT still need to conduct initial assessments and develop a plan of care for maintenance if there is no need for individual treatment?

A: Requirements for multidisciplinary team assessments and care plan development based on assessed needs in the current ADHC program will continue to apply to the new CBAS program, including for the need for and provision of maintenance program services.

- 10.Q: Do we need a social worker or MSW for CBAS?

A: Yes. Requirements for staffing in the current ADHC program will continue to apply to the new CBAS program, including employment of social work staff.



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11.Q: Does the moratorium apply to new providers for CBAS?

A: Not directly, but indirectly. The moratorium, which was imposed pursuant to Welfare and Institutions Code Section 14043.46, applies to the ADHC program. However, CBAS has its own limitation which acts similar to a moratorium. Without exception, in order to qualify as a CBAS provider, a center is required to have been licensed as an ADHC provider as of December 1, 2011.

12.Q: Is it mandatory for existing clients to have Medi-Cal to qualify for CBAS?

A: Yes. CBAS participants are by definition Medi-Cal participants. Licensed ADHC centers may continue to serve non-Medi-Cal, private pay participants.

13.Q: Does CBAS end in 30 months along with the settlement?

A: Beginning March 1, 2012, CBAS services will be authorized under the 1115 Bridge to Reform federal waiver for the duration of the waiver, which the Department expects to be approved through October 31st, 2015.

14. Q: Can CBAS providers accept private pay ADHC and adult day program (ADP) participants at the same center under the same license?

A: ADHC centers that are licensed to provide both ADHC and ADP services may continue to do so with one ADHC license either with or without approved CBAS provider status. ADHC services will not be reimbursed by Medi-Cal after February 29, 2012.

15. Q: Are February reassessments required for a March 1, 2012, effective date?

A: Yes. Multidisciplinary team reassessments will continue to be required on their current schedule for all approved CBAS participants. For example, for a participant determined to be CBAS eligible and continuing at the same center, who has a TAR set to expire on May 1, 2012, the center's MDT would conduct reassessments for that participant during April 2012, within 30 days of TAR expiration.

16.Q: If we opt to apply to be a CBAS provider, but do not have enough CBAS eligible clients to continue operations, what needs to be done?



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A: The decision whether to continue to operate is a business decision that your organization must make. By February 15, 2012, CDA will publish the list of approved CBAS providers statewide (www.aging.ca.gov/programs/ADHC). This list, along with information provided by DHCS regarding your center's CBAS eligible participants, should assist with your decisions.

17. Q: What is the main difference between the participants that ADHC serves and the ones CBAS serves?

A: Since CBAS eligibility requirements are more specific and restrictive, the minimum level of care need is higher.

Managed Care Questions

18. Q: When will we be able to apply for a contract with the managed care providers? I already emailed one of the Medi-Cal managed care providers and have not received a response

A: Medi-Cal managed care plans whose beneficiaries are determined to be eligible for CBAS will begin reaching out to the CBAS providers after March 1st.

19. Q: Do we need to complete an application with the managed care organizations that serve our participants?

A: Yes. Each managed care plan will have a contracting and credentialing process that will be communicated to CBAS providers in their area.

20. Q: When will we have a chance to move our participants to managed care?

A: Participants who qualify for managed care have the right to choose a managed care plan at any time by calling Health Care Options at 1-800-430-4263. Notices and enrollment packets explaining how to enroll into a managed care plan will be sent to ADHC Class members who qualify for managed care 90 days prior to CBAS becoming a managed care benefit on July 1, 2012. A follow up 60 day notice and 30 day notice will be sent as well.



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Treatment Authorization Request (TAR) Questions

21.Q: Will the TAR and IPC forms still be used under CBAS?

A: Yes. The TAR form remains the same. The ADHC IPC will be revised to reflect new CBAS eligibility and medical necessity criteria.

22.Q: Do we need to submit new TARs as of March 1, 2012, for all approved CBAS participants?

A: No. CBAS providers will continue to submit TARs and IPCs for services after March 1, 2012, on the same expiration schedule participants are on for ADHC services.

23.Q: Will there be a new IPC form in March to replace the current IPC form?

A: Yes. The TAR form remains the same. The ADHC IPC will be revised to reflect new CBAS eligibility and medical necessity criteria and become effective March 1, 2012.

24.Q: If we do not have managed care in our area who will conduct six month assessments?

A: DHCS will conduct on-going assessments. Medi-Cal Fee-for-Service will provide CBAS services for CBAS-eligible beneficiaries who do not reside in counties where Medi-Cal Managed Care is available or who are otherwise ineligible for Medi-Cal Managed Care enrollment.

25.Q: Are we still going to submit TARs to the Medi-Cal field office once we transition to CBAS in March?

A: Yes.

26.Q: Once our center is approved as a CBAS provider, can we serve Medi-Cal participants who are not currently in the program? Will they be assessed in person by DHCS later?



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A: Effective March 1, 2012, CBAS providers may enroll new participants who meet CBAS eligibility criteria. DHCS nurses will conduct face-to-face assessments as a function of TAR approval.

27.Q: How will current ADHC participant TAR periods be affected by the March 1 CBAS start date? Will participants continue on the current TAR schedules?

A: CBAS-eligible participants will continue on their same TAR schedules after March 1, 2012.

Waiver Questions

28.Q: Is there a cap on participants who can receive CBAS services?

A: There is no cap on the number of participants who can receive services. However, the number of participants who can be served at any one time will be limited by the capacity of CBAS provider centers.

29.Q: When will we receive the 1115 waiver?

A: DHCS submitted an 1115 waiver amendment for CBAS on January 10, 2012. The 1115 waiver amendment request is available now on the DHCS CBAS/ADHC Transition website at:
www.dhcs.ca.gov/services/medi-cal/Pages/ADHC